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SOCIAL SECURITY AMENDMENTS OF 1971

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HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST AND SECOND SESSIONS

ON

H.R. 1

TO AMEND THE SOCIAL SECURITY ACT TO INCREASE BENEFITS AND IMPROVE ELIGIBILITY AND COMPUTATION METHODS UNDER THE OASDI PROGRAM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS ON IMPROVEMENTS IN THEIR OPERATING EFFECTIVENESS, TO REPLACE THE EXISTING FEDERAL-STATE PUBLIC ASSISTANCE PROGRAMS WITH A FEDERAL PROGRAM OF ADULT ASSISTANCE AND A FEDERAL PROGRAM OF BENEFITS TO LOW-INCOME FAMILIES WITH CHILDREN WITH INCENTIVES AND REQUIREMENTS FOR EMPLOYMENT AND TRAINING TO IMPROVE THE CAPACITY FOR EMPLOYMENT OF MEMBERS OF SUCH FAMILIES, AND FOR OTHER PURPOSES

JULY 27, 29; AUGUST 2 AND 3, 1971, AND
JANUARY 20, 21, 24, 25, 26, 27, 28, 31; FEBRUARY 1, 2, 3, 4, 7, 8, AND 9, 1972

PART 5 OF 6 PARTS

Public Witnesses

(February 4, 7, 8, and 9, 1972)

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SOCIAL SECURITY AMENDMENTS OF 1971

FRIDAY, FEBRUARY 4, 1972

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Harris, Byrd of Virginia, Nelson, Bennett, Curtis, Jordan of Idaho, Fannin, and Hansen.

Also present: Senator Hatfield.

The CHAIRMAN. The committee will come to order.

We are pleased to have with us as the first witness this morning the Senator from Missouri, the Honorable Thomas F. Eagleton.

Senator EAGLETON. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Eagleton, we are pleased to have your views on this welfare bill.

STATEMENT OF HON. THOMAS F. EAGLETON, A U.S. SENATOR FROM THE STATE OF MISSOURI

Senator EAGLETON. Mr. Chairman, I appreciate the opportunity to appear before the Committee on Finance today. Although there are many sections of H.R. 1 that are vitally important to older Americans, I am going to confine my remarks to title III, which would establish a new program of assistance to the aged, blind, and disabled.

Today nearly 5 million persons 65 and over live on incomes below the official poverty line. Forty-seven percent of all single or widowed elderly people live in poverty.

Naturally, those who were poor during their working years remain poor in old age. But many others fall into the poverty category for the first time after retirement—when their savings have been depleted and they must live on inadequate social security benefits.

The very fact that one-fourth of our older citizens live in this condition testifies to the failure of our present public assistance programs.

In fewer than 20 States does old age assistance provide an elderly person as much as \$150 per month to purchase the necessities of life—food, shelter, clothing, medical care. As of July 1, 1971, nine States, including my own, gave that person less than \$100 per month.

Moreover, old age assistance programs reach only half of the elderly poor. There are at least 2 million persons who would be eligible for assistance but, for a variety of reasons, do not receive it.

Many of the problems our society faces are complex and not susceptible of easy solution. But poverty among the elderly is really not one of them.

We can—and I believe we should, at the earliest possible date—assure every older American a minimum level of income. Furthermore, we should provide this assistance in a way that is not destructive of the dignity and self-respect of the individual.

I am hopeful that ultimately social security coverage will be so universal and benefits sufficiently adequate that the need for supplemental assistance will be greatly diminished, if not obliterated.

But for the immediate future, I believe the objectives I have stated can best be achieved through the Federal financing and Federal administration of a national floor of income for the aged, blind, and disabled with uniform eligibility and payment standards.

There are a number of ways in which title III could and should be improved. I have introduced two amendments for the consideration of the committee which I would like to describe very briefly.

First, as passed by the House of Representatives, the floor of income in the adult assistance program, to be phased in over a 3-year period, would never reach official poverty levels. By the third year of the program—originally fiscal 1975, now fiscal 1976—benefits would approximate only 1970 poverty levels.

The amendment I have proposed would set the initial income floor at \$150 for an individual and \$200 for a couple, thus eliminating the 3-year phase-in. In addition, it would provide for annual cost-of-living adjustments in those benefit levels.

Because there is considerable doubt as to the adequacy of the poverty thresholds as a measure of income need, my amendment would direct the Secretary of Health, Education, and Welfare to conduct a study to determine the amounts of income required to provide for the basic needs of the aged, and submit to Congress his recommendations for appropriate adjustments in the benefit levels under the adult assistance program.

Second, as we make the transition from the many diverse State programs to one uniform Federal program, I believe it is essential that we guarantee that no current recipient of assistance will be adversely affected. The transitional provisions and fiscal incentives now in H.R. 1 cannot provide that guarantee.

All or some recipients in at least 30 States would receive less assistance under the new federal program than they now receive unless the Federal benefit were supplemented by the State.

In Missouri, my State, those recipients who have no other income would benefit substantially from the new Federal program. But many of those who have a small social security benefit or other income would receive less, unless the State provided supplementary payments.

Under title III, as now written, such supplementation is optional. No Federal matching funds are provided for supplementary payments. A State would only be guaranteed that its supplementary payments for both adults and families would cost it no more than its expenditures for the same purposes in calendar 1971.

Section 509 of the bill would prevent any automatic reduction in assistance at the time of the transition, by providing for maintenance of assistance levels until a State took affirmative action to reduce or stop its supplementary payments.

No doubt many—perhaps even most—States would voluntarily continue their supplementary payments. But given the fiscal pressures on

State governments and the lack of real fiscal relief in H.R. 1, I do not believe we should assume that, with those options, no State will act to reduce or discontinue its supplementary payments.

In addition to the need for supplementation, there may be questions as to the continued eligibility of some recipients. For instance, in certain States the blind have traditionally been permitted income and resources in excess of what would be allowable under the new program. A blind couple in Missouri with savings totaling \$3,000 apparently would have to dispose of half of their savings in order to become eligible for the Federal benefit and/or State supplementation.

I believe that no aged, blind, or disabled person who now relies upon public assistance should be subjected to uncertainties and anxieties about what will happen to that assistance either at the time of the transition to the new program or at some time in the future when a State government may change its policy.

My second amendment, therefore, would guarantee the continued eligibility for assistance, and maintenance of assistance levels, for all those receiving aid to the aged, blind, and disabled under an approved State plan at the time of the transition to the Federal program.

It would, in effect, "grandfather" all such persons into the new program. The States would be required to provide the supplementary payments necessary to maintain the level of assistance those people had been receiving. The supplementary payments would be administered by the Federal Government, and the Federal Government would contribute 30 percent of their cost.

Finally, Mr. Chairman, I would like to bring to the committee's attention a matter that is of great significance to the blind people of my State. Since 1921, Missouri has had a State blind pension program which encourages rehabilitation and self-reliance by a liberal disregarding of income and resources.

Because this program did not meet requirements of Federal law, Missouri did not receive Federal funds for aid to the blind prior to 1950. At that time, a special temporary exemption was written into the Social Security Act, which permitted approval of State plans for aid to the blind in Missouri and in Pennsylvania—which has a similar blind pension program—on the condition that Federal payments would be made only with respect to assistance rendered to the needy blind. This temporary exemption was extended on two occasions and was finally made permanent in 1962.

As a result of this exemption, Missouri has had since 1951, dual programs for the blind: The Federal-State aid to the blind program, and also a wholly State-financed blind pension program for those persons who, because of their income or resources, are not eligible for aid to the blind.

The blind people of Missouri are understandably proud of their blind pension program. They have worked diligently over the years to maintain it, and they do not want it to be jeopardized in any way by federalization of the adult categories.

If the committee approves the establishment of a Federal adult assistance program, I join with the American Council of the Blind and the Missouri Federation of the Blind in urging that language be included in title III, which will exempt the blind pension programs of Missouri and Pennsylvania from any Federal requirement or regula-

tion that might be imposed on other cash payments made by those States as "supplementary payments."

There are other modifications that might be made in title III. For instance, it seems to me that the allowable resources for a married couple should be somewhat greater than for a single person.

Mr. Chairman, I want to conclude my statement by urging in the strongest possible terms that this committee give its approval to the kind of program that can alleviate the poverty among those of our fellow citizens who, because of age or disability, can no longer provide for themselves. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Eagleton.

Senator EAGLETON. Thank you so much.

(The committee subsequently received the following communication relevant to the preceding testimony:)

MISSOURI FEDERATION OF THE BLIND, INC.,
February 1, 1972.

Senator RUSSELL LONG,
Senator From Louisiana, Chairman, Senate Finance Committee, Senate Office Building, Washington, D.C.

DEAR FRIEND: I received a copy of your press release concerning hearings on H.R. 1. The blind of Missouri were overjoyed when you expressed your feelings about the welfare program. The blind of Missouri have always protected the ambitious and industrious blind so that they lose no benefits until they become entirely self supporting.

Our program in Missouri since its origination has always been a flat rate pension and has never been based exclusively on need. When it originated in 1922, we had a figure of \$600 exempt earnings and \$25 a month pension. We have fought hard to maintain the major principles of our program through the years and feel that we were successful. However, H.R. 1 as it stands now, would wipe it out.

We are happy that Senator Eagleton, with the cooperation of Senator Symington has prepared amendments and introduced them in the Senate in our behalf, and we hope that your Committee will consider them fairly and be able to wholeheartedly support them.

We thank you for your sincere interest and intelligent approach to the welfare problem and we hope for many more years of your leadership in the United States Senate.

Your friend,

G. ARTHUR STEWART.

The CHAIRMAN. In view of the heavy list of witnesses I am going to suggest to all members wherever possible we submit our questions in writing and submit them to the witnesses.

The next witness is the Honorable Phillip Burton of California. Is he here? He does not respond.

The next witness will be the Honorable Allen Dines, State senator from Colorado; and Hon. Charles F. Kurfess, Speaker, Ohio House of Representatives, in behalf of the National Legislative Conference.

STATEMENT OF CHARLES F. KURFESS, SPEAKER, OHIO HOUSE OF REPRESENTATIVES, ACCOMPANIED BY ALLEN DINES, STATE SENATOR, COLORADO; AND RICHARD S. HODES, STATE REPRESENTATIVE, FLORIDA, IN BEHALF OF NATIONAL LEGISLATIVE CONFERENCE

Mr. KURFESS. Mr. Chairman, I am Speaker Kurfess of Ohio. To my immediate right is State Senator Dines of Colorado; and further to his right is Representative Richard Hodes of the State of Florida.

Mr. Chairman, we appreciate very much the opportunity to testify before the committee this morning. We are here representing the National Legislative Conference to discuss the welfare reform legislation which you now have under consideration.

We three here at the table are State legislators and will be presenting this testimony. We are members of the Human Resources Task Force of the Intergovernmental Relations Committee of the National Legislative Conference. Other task force members are here and seated behind us and I think you have a list of these members before you.

While there are many aspects and details of H.R. 1 which we are concerned with, this morning we will focus our attention in basically five areas.

First of all, the area of national uniformity and the States' role. Outlining those elements of a welfare and related services program that can have national uniformity and those elements that require a State role or options to deal with area and State variations and be administratively workable.

Secondly, we will present suggested amendments to the bill to improve the services programs contemplated and including specific examples of States' efforts to provide public service employment and a specific example of a State's effort to provide comprehensive, one-stop social service delivery system.

Third, in the area of child support we will present suggestions to improve the ability of States to enforce child support payments by fathers or responsible relatives.

In the area of medicaid financing we will suggest changes in the medicaid provisions to increase rather than decrease the Federal participation in the cost of medicaid, as I am sure this committee is aware of the impact that medicaid has had on some States' resources.

And finally, in the area of fiscal relief we would suggest some changes in these provisions to make more equitable between the States the fiscal relief and to allow among the States for the variations in the cost of living increases.

With regard to our analysis of what we feel are the variations that should be made with regard to Federal and State roles in defining social problems and solutions, with regard to this bill, we have really looked at the bill and asked ourselves two questions, and we would draw your attention to them.

First, what should or can be the extent of the national definition of the problem that we will be dealing with, and what can be determined and defined only or at least best on a State-by-State basis.

And, secondly, what should be or can be the extent of the national prescription of a solution to the problem requiring national uniformity, and in what areas should be or must we rely on the State-by-State solution of the outcome of the problems not requiring national uniformity.

Some of the nationwide variations which we feel must be taken into consideration are the characteristics of the unemployed, who are the present welfare recipients and the low income people; we should recognize the variation and average income levels, wages and cost of living among the various regions of the Nation and States; in fact, some of these variations are within the States themselves.

We should recognize the differences in educational, social or occupational skill levels of welfare and low-income individuals in an area or State. We should recognize the present extent and organization for delivery of public human services in the various States which do vary from State to State, the availability of private employment or potential public service employment, and the location and mobility of the unemployed in relation to present or potentially available private or public jobs.

We would like to point out that in the areas that there is flexibility now in Federal legislation to deal with State and area differences. This flexibility is often provided only to the Federal administering agency of these programs and not to State officials.

Therefore, we would ask that statutory flexibility to deal with State and area variations instead be explicitly provided at the State level.

In dealing with the cash assistance program standards and policies, we see the need for the Federal Government to establish the minimum standards for cash assistance which would be fully federally financed and applied throughout the country.

It also appears that we should have some uniform national policy with regard to liens on recipients' property in the amount of allowable resources in determining eligibility.

However, it is also essential that we recognize the variations in the income levels, wages and cost of living between the States and within areas of the States. We, therefore, suggest variations in the supplementary payments provision to provide States the option of continuing the practice now in a number of institutional and community care payments.

In addition, States which now provide the same payment for an individual, whether living as an individual or with their spouse as a couple under the old age assistance program, should have the option to continue such a practice.

We believe that national uniformity in the establishment of a uniform definition of employability is reasonable. Present loss provision regarding that amount of income which may be disregarded in determining eligibility for assistance payments has seen the gross income of families still receiving some payment rise to such levels that the entire program of providing work incentives for low-income people has suffered.

Thus we propose that the States have the option to apply some limitation on the gross income of eligible families at which point they would no longer be eligible for State supplementary assistance.

Among the options we feel should be available to States is flexibility in the use of a State's supplementary payment program, provide incentives for welfare recipients to relocate near available employment. In some cases this may mean providing incentives to move to more rural areas with lower costs of living, especially for housing and where employment opportunities may exist.

The key questions which must be dealt with in determining the division of responsibility between the Federal and State Governments for administering cash assistance and manpower, social rehabilitation, child care and other related services, include what arrangements can provide the most responsiveness to the needs of the people served; what arrangements can provide the most efficient administration, in-

cluding the use of the newest administrative procedures and technology; what arrangements can provide the most effective link and interrelationship among related services.

While persistent arguments have been made for the desirability of Federal administration of cash assistance programs, continued State participation in financing the supplementary payments, in our judgment, makes it essential that States have the option to administer the cash assistance program if they desire without the financial penalties which their exercise of such an option proposes in H.R. 1.

These same differences then between the requirements of national uniformity and options to the State exist throughout, in our judgment, your considerations of the bill.

At this point I would draw your attention to page 2 of the printed material I think you have before you, which is basically an outline of the proposed Federal-State division of responsibility in welfare reform legislation which we can submit to you providing, in our judgment, those areas where national uniformity is probably required and also in those areas in which we think the State has a responsibility and a role and variable options must be made available to the States.

Senator CURTIS. Mr. Chairman, may I ask a question at that point?

Mr. KURFESS. Yes, Senator.

Senator CURTIS. Referring to that third page on the left-hand side, "Federal financed national minimum payment standard," would you elaborate on that, as to just what you mean?

Mr. KURFESS. I think what we are suggesting here is a recognition that essentially the cash assistance payment program in some respects has become a national, legitimate national, concern. This is because of the mobility of the population, which I am sure has been pointed out to the committee on many occasions. It is because of some court decisions which have removed residence requirements, and in order that, we feel, there should be rightfully a decision made at the national level on what minimum income should be assured.

Senator CURTIS. But it says Federal financing.

Mr. KURFESS. Yes.

Senator CURTIS. Are you recommending that the minimum standard payment which a State might well choose not to supplement should be totally federally financed?

Mr. KURFESS. If it is—yes, if it is a minimum established at the Federal level for a nationwide import, yes.

Senator CURTIS. Well, what I am getting at is, are you recommending that this burden be taken away from the States and placed entirely on the Federal Government?

Mr. KURFESS. Well, I would suggest, Senator, in some respect that this burden is already by Congress' option with the Federal Government, because much of—and this varies from State to State, but in our State, for instance, half of the payments now are federally financed.

Senator CURTIS. Yes, and what I want to know is, are you recommending that the Federal Government finance it all?

Mr. KURFESS. Only up to whatever minimum the Congress would establish.

What we are really suggesting here is that this is a national policy question.

Senator CURTIS. Well, sure, it is of national concern, it always has been, and there is no State that doesn't get 50-percent matching now and some of them get considerably more, but I gather that what this recommendation means is that the burden would become totally Federal.

Senator FANNIN. Would the Senator yield?

Senator CURTIS. Yes; I am through.

Senator FANNIN. I would just like to ask the witness, you would require that the Federal Government take the full load of medicaid, for instance?

Mr. KURFESS. This will be commented on a little bit later in our presentation, if we might, Senator.

Senator CURTIS. That is all.

Mr. KURFESS. At this point, if I might, members of the committee, in drawing your attention to it, I think it is page 3 probably which you have before you, which is basically the outline, as I indicated, of our judgment as to what aspects should be determined by national determination and have uniformity across the Nation, in those areas in which the States should have the primary role and responsibility and certainly options available to them, I draw your attention to that and ask Senator Dines, if he would, to continue the presentation on behalf of the committee.

Mr. DINES. Members of the committee, if I may respond also to Senator Curtis' question, I think the answer is, from my standpoint, at least, is yes, that we would recommend to you a minimum level of assistance to be totally funded by the Federal Government at whatever minimum you gentlemen care to set that would apply nationwide. After that we would like to see options with the States to supplement that minimum.

I think we would also like to see some Federal participation in the supplementary payments at least up to the current levels that the States are paying. There are some further problems with cost-of-living increases, for example, that may be required henceforth, and our position would be that we would like to see Federal participation in those reasonable supplements to the minimum national standard. We don't advocate an open-ended appropriation whereby you would have no control at all on what the States did with your money; that is not our intention.

If I may, on this page, discuss several of these items, because this is really the key to our interest in the bill and our contribution, if any, to your consideration of it. We think that there are, as Speaker Kurfess has mentioned, a number of items that ought to be uniform and a number that ought to vary from State to State, and be permitted to vary. We have divided this into three categories. You will notice the first items at the top of that page deal with cash assistance program standards and policies, and I think we have adequately covered the two items on the uniform column.

The State options which we would recommend deal with intrastate variations in the amount of the supplementary payment as, for example, wherein some States a payment supplement for shelter is much more expensive in some parts of the State than in others. If this were to be established at the Federal level on a uniform basis it would be

impossible, in our view, at least, to take into account those local variations.

The second item also covers not only shelter but covers institutional and community care payments, where a person may be placed in a boarding home situation or a community facility that is not especially health oriented, and the actual cost of that payment may have to be part of the supplement that a State provides, and will vary not only from State to State and region to region within a State, but will vary with the particular boarding home the person is placed in.

The third item has already been mentioned and that involves States where the policy has been adopted to pay an individual a given amount of money as a standard, and to pay a couple not a reduced amount but exactly double the amount that an individual would get.

In my own State of Colorado that has been the policy for at least 35 years, I believe, and we would be hard pressed if the Federal Government were to refuse to participate in that local policy of long standing.

I think there are other illustrations of that where that will be very important to the States.

The next heading then is in work requirements and incentives, a very important part of the bill, and one which we think can be uniformly applied insofar as a definition of employability is concerned, although that term is hard to apply even if you can define it in statute, but the definition ought to be uniform.

The minimum wage at which a recipient must accept employment as a condition of eligibility, we can understand that that might well be a uniform proposition, and indeed in H.R. 1 I think it does specify that a person must accept employment if the job offers a salary of three-quarters of the national minimum wage, so this is an incorrect way of applying a national minimum wage, and that can be uniform.

There are also uniform disregards of income on the national minimum payment standards. This leads us into an awkward position, however, which I would like to mention because as the bill is now written the income disregards are credited in reduction of the Federal payment and not at all in reduction of the State supplement. We don't feel that that is equitable, and would like to see you consider applying those payments, some of our members think that they ought to be applied entirely to the State supplement first, but even if that were further than you wished to go or felt you could go, we think there is real merit in the suggestion that they be applied proportionately to the State and the Federal payments.

A third possibility, which may be even more acceptable to you would be to write into the bill a provision that States should have the option to set maximums after which the State supplement would not apply. For example, one might say that in no case would a State be required to pay if the Federal standard and the disregards added to more than perhaps 150 percent of the State standard payment. In this way the disregards could not add up to such a sum that the recipient is really getting much more income than the State would be inclined to give were it to start without those disregards.

There should also be, as Speaker Kurfess has mentioned, an option for the States to experiment with supplementary payments to en-

courage a recipient to relocate as from one part of the State to another in order to take a job.

The final section deals with the administration of the cash assistance and services, and here we list on the left the uniform recipient identification system, uniform performance standards, and accountability for the use of Federal funds, uniform data, and statistical systems necessary for proper planning and evaluation, the availability of Federal information for the use in locating nonsupporting fathers, this is particularly important, and we will refer to it later on, if we may, and a uniform national system for identification of available jobs to the employment service.

But while making those things uniform we would suggest that the States be preserved the option of administering the cash assistance program both for families and for adult categories without financial penalty.

At the present time the bill is written so that the States may continue some of this administration, but if they do it will be at their own expense, and the hold harmless provisions of the act would not apply. We feel this is an unnecessary club to force States to agree that Federal administration of these payments is a better system than State payments and, naturally, speaking on behalf of State legislatures we are reluctant to make that concession. We think there are advantages in a certain amount of local control, and a certain amount of experimentation with how administration can best proceed.

Senator ANDERSON. I have to warn you time is running pretty rapidly.

Mr. DINES. I think I have covered the points that were assigned to me, and would like to ask Representative Hodes of Florida if he would deliver a short statement on the social services aspect which we feel is very important.

Senator ANDERSON. Very well.

Mr. HODES. Members of the committee, I will just take a few moments. I am here primarily because I am chairman of the Committee on Health and Rehabilitative Services of the Florida House of Representatives. I am going to direct your attention primarily to the matter of services delivery as they are related to this particular proposed legislation. The key provision in this bill is one which would provide that there would be a freeze on those funds available through titles IV(A) and XVI, and would have the effect of limiting the availability of Federal assistance for potential welfare recipients under the programs currently in effect. It would tend to deny those States that choose to continue to innovate in the area of potential recipients in the rehabilitative programs from the opportunities of having Federal assistance in innovation. The damaging aspect of this is that it would discourage development of improved services by States in that it would freeze them at the present level and any development programs they would have would have to relate solely to their own tax base.

I can recognize the thrust of the freeze concept since IV and XVI services today are aimed at many who would come under the eligibility of the new program and the new program contemplates a different sort of service.

However, it is important that individuals in both categories, the working poor and unemployables, are usually seriously in need of social and health services that are available only through State agencies.

The classical assistance offered by social workers and vocational rehab counsellors is often insufficient to met the needs of many families on public assistance or who are potential public assistance recipients in the titles IV(A) and XVI categories. So while we have social workers who provide excellent intake and excellent referral functions to other State agencies they usually in themselves are unprepared to resolve some of the problems of America's poor.

It is our concept in Florida, and we have already funds to initiate this, that the key to effectiveness of these services is coordination. For example, a single recipient family may have correctional, psychiatric, or emotional problems and could best be treated by State agencies by integration of programs of this nature.

At the present time Florida is attempting to demonstrate this under a concept that we developed in the Palm Beach County under Federal grant under the name of a Comprehensive Services delivery system. We refer to this by the acronym of the CSDS project and this project has only been operative for a short time but there are some case studies, of which you have been given copies, which illustrate very brief and very simple cases of how this coordinated concept works. The idea is that legislation should be designed not to discourage but to encourage improved State services by treating the multiple disabilities of the poor by making them available to the poor without having to shop around from agency to agency.

I would like to suggest that social services funds be made available to provide incentives for creating a coordinated social services system. Such a system could embody State control and comprehensive delivery. The present fragmentation of services wherein the potential recipient, although he may be eligible or ineligible for cash assistance, has to shop around for months at a time from one agency to another to find the appropriate social services should be discouraged. What we should have is a coordinated comprehensive service delivery system available by a coordination of these services within a State where a single State agency has overall an overview of this and delivers these services and makes them available to recipients at a local level.

The design of a comprehensive services delivery system at State level should be encouraged by the provision of matching funds for this purpose and not by just freezing any further innovation under the proposed sections of this bill.

The agencies that insist upon separate and exclusive control should be discouraged, and the encouragement of comprehensive State services for disabilities to the poor can result, we believe, in a marked increase in the employable among the unemployable, and the level of income among the employable.

The posture of the bill encouraging day care planning should be included in the comprehensive delivery system because we find the greatest reason for disability and the greatest reason for unemployability is the absence of child care services and, of course, the growth of the program is due to the absence of family planning services.

The chairman's own State of Louisiana is exemplary in the value of family planning service and what it can do to hold down welfare costs in a State, so I would encourage the committee, in fact urge the committee, to try to amend this legislation so that it does not deny the States the opportunity for innovation in the services delivery area outside of the public assistance role and even the vocational rehab role but, in fact, amend the legislation to encourage all States to develop comprehensive services delivery, both within the superstructure of State government and also to have comprehensive service delivery programs at the local level so that a single recipient can, as we have demonstrated in Palm Beach, can complete an interview application by every State agency for possible eligibility for need of services within a matter of a couple of hours. This is very, very efficient. It saves a great deal of money and it would go a long way from removing people from the unemployable category and placing them in the employable category which would then assign them to perhaps some other agency, as is contemplated in the bill through the Department of Labor.

The biggest value of this type of system, too, would be to develop a job profile wherein that job profile could be plugged into a Commerce or Labor Departments job availability structure and proper matching of jobs and individuals could be taken care of. At the same time whatever disabilities exist in the family that have been provided to the State agencies can be delivered. This could cover behavioral problems, mental health problems or just simply vocational educational problems. These could all be covered by having a comprehensive system, and the legislation should encourage coordinated comprehensive service delivery systems at the State level with Federal assistance. Thank you.

Mr. KURFESS. Mr. Chairman, I understand your time is limited this morning. I would like to thank you for this opportunity that we have had to make this presentation to you. We want to emphasize, as our outline indicates to you, our concern from our position as policymakers at the State level, and certainly indicate to you that as you continue your consideration of this measure we will be happy to respond to any questions or reactions that you might want from us.

Senator ANDERSON. I think it is a very good statement. You have made some very good comments. We will take advantage of your observations. It is extremely valuable.

Any questions?

Senator FANNIN. Mr. Chairman, this certainly presents very fine testimony. It is regrettable we do not have more time because I know we will benefit from your testimony and we will read your complete statement.

I am just wondering if you could furnish for the record from the National Legislative Conference the percent that medicaid costs are to the total welfare costs in the individual States. We have had that furnished for some of the States but not for all. I wonder if that is available from the National Legislative Conference.

Mr. KURFESS. We would certainly get it for you.

Senator FANNIN. Thank you kindly. I appreciate very much your testimony.

(The prepared statement of Mr. Kurfess and a table referred to by Senator Fannin follows. Hearing continues on p. 2268.)

Total expenditures for medical assistance, and welfare expenditures broken by percent of expenditures for medical assistance and cash assistance plus social services, fiscal year 1971

	Expenditures for medical assistance	Percent of expenditures for—	
		Medical assistance	Cash assistance plus social services
Alabama.....	82,702	34.1	65.9
Alaska.....			
Arizona.....			
Arkansas.....	12,631	10.9	89.1
California.....	1,109,164	34.0	66.0
Colorado.....	56,223	47.8	52.2
Connecticut.....	97,743	44.9	55.1
Delaware.....	7,482	26.0	74.0
District of Columbia.....	39,857	35.4	64.6
Florida.....	83,516	32.4	67.6
Georgia.....	129,995	38.5	61.5
Guam.....	495	21.3	78.7
Hawaii.....	22,249	39.7	60.3
Idaho.....	10,483	34.9	65.1
Illinois.....	287,680	33.7	66.3
Indiana.....	53,972	31.0	69.0
Iowa.....	27,115	21.0	79.0
Kansas.....	39,910	30.0	70.0
Kentucky.....	71,002	35.6	64.4
Louisiana.....	54,824	20.1	79.9
Maine.....	18,802	24.7	75.3
Maryland.....	108,227	41.9	58.1
Massachusetts.....	343,092	46.0	54.0
Michigan.....	277,512	39.0	61.0
Minnesota.....	113,295	38.3	61.7
Mississippi.....	35,835	26.8	73.2
Missouri.....	60,453	22.9	77.1
Montana.....	11,150	34.6	65.4
Nebraska.....	24,402	30.7	69.3
Nevada.....	8,276	38.8	61.2
New Hampshire.....	7,665	24.4	75.6
New Jersey.....	181,669	32.8	67.2
New Mexico.....	17,571	26.0	74.0
New York.....	1,555,518	49.0	51.0
North Carolina.....	98,187	40.9	59.1
North Dakota.....	13,382	39.6	60.4
Ohio.....	131,746	29.5	70.5
Oklahoma.....	96,350	37.6	62.4
Oregon.....	19,961	15.5	84.5
Pennsylvania.....	363,405	37.6	62.4
Puerto Rico.....	71,383	56.3	43.7
Rhode Island.....	42,189	44.6	55.4
South Carolina.....	34,412	42.2	57.8
South Dakota.....	9,037	26.4	73.6
Tennessee.....	38,840	20.5	79.5
Texas.....	181,587	28.8	71.2
Utah.....	18,845	33.0	67.0
Vermont.....	15,508	39.4	60.6
Virgin Islands.....	1,337	44.5	55.5
Virginia.....	58,944	33.2	66.8
Washington.....	105,073	34.1	65.9
West Virginia.....	23,320	25.5	74.5
Wisconsin.....	162,848	54.8	45.2
Wyoming.....	1,828	17.9	82.1
U.S. total.....	6,434,692	37.1	62.9

STATEMENT OF SPEAKER CHARLES F. KURFESS, OHIO HOUSE OF REPRESENTATIVES;
STATE SENATOR ALLEN DINES, COLORADO, CO-CHAIRMAN; AND STATE REPRESENTATIVE
RICHARD S. HODES, FLORIDA, ON BEHALF OF THE HUMAN RESOURCES TASK
FORCE OF THE INTERGOVERNMENTAL RELATIONS COMMITTEE OF THE NATIONAL
LEGISLATIVE CONFERENCE

SUMMARY

Mr. Chairman, we appreciate the opportunity to testify before this Committee to represent the National Legislative Conference to discuss the welfare reform legislation now under consideration. The panel of state legislators which will present this testimony are members of the Human Resources Task Force of the Intergovernmental Relations Committee of the National Legislative Conference. Other members of the Task Force and their staff are also here today. We have provided to the Committee the list of those in attendance today.

While there are many aspects and details of H.R. 1 that we are concerned with, we have focused our attention on the following:

I. *National Uniformity and State Role.*—Outlining those elements of a welfare and related services program that can have national uniformity and those elements that require a state role or options to deal with area and state variations and be administratively workable.

II. *State Role in Services.*—Present suggested amendments to H.R. 1 to improve the services programs contemplated and including specific examples of States' efforts to provide public service employment and a specific example of a State's effort to provide comprehensive, one-stop social service delivery system.

III. *Child Support.*—Presenting suggestions to improve the ability of States to enforce child support payments by fathers.

IV. *Medicaid Financing.*—Suggest changes in the Medicaid provisions to increase rather than decrease the federal participation in the cost of Medicaid.

V. *Fiscal Relief.*—Suggest changes in the fiscal relief provisions to make more equitable between States the fiscal relief and allow for cost of living increases.

PROPOSED FEDERAL-STATE DIVISION OF RESPONSIBILITY IN WELFARE REFORM
LEGISLATION

National Uniformity

State Role and Options

CASH ASSISTANCE PROGRAM STANDARDS AND POLICIES

- | | |
|---|--|
| 1. Federal financed national minimum payment standard. | 1. Intrastate variations in amount of state supplementary payments reflecting cost variations within the State. |
| 2. Uniform policy on liens and allowable resources for eligibility. | 2. State option to alter amount and nature of state supplementary payment in providing shelter allowances and institutional and community care payments. |
| 3. Uniform definition of employability. | 3. State option in supplementary payments to change ratio of total amount of payments between individual and couple payments under old age assistance. |

WORK REQUIREMENTS AND INCENTIVES

- | | |
|--|---|
| 4. Minimum wage at which recipient must accept employment as condition of eligibility. | 4. Option to State in determining eligibility for state supplementary assistance to apply a gross income limitation of eligible families to no less than 150% of the State's payment level. |
| 5. Uniform income disregards on national minimum payment standards. | 5. Option to State to provide incentives to recipients with state supplementary payments to relocate near available employment. |

ADMINISTRATION OF CASH ASSISTANCE AND SERVICES

6. Uniform recipient identification system.
7. Performance standards and financial management policies for accountability in use of federal funds.
8. Uniform data and statistical system for planning and evaluation.
9. Availability of federal agencies information for use in locating non-support fathers.
10. Uniform national system for identification of available jobs.
6. State option for state administration of cash assistance program for families without financial penalty.
7. State option for state administration of cash assistance program for the aged, blind, disabled, without financial penalty.
8. Continued state responsibility for administering enforcement of father support with state option to develop sanctions for use in locating and enforcing father support.
9. State option to submit a Comprehensive State Opportunities for Families services plan for manpower, public service employment, child care and related social, rehabilitation, and health services.
10. State determination of order of priority for employable individuals to receive Opportunities for Families services.
11. State administration of social services for the aged, blind, disabled, and families with continued availability of adequate funds and flexibility in their use to enable States to develop and provide comprehensive social services.

I. FEDERAL AND STATE ROLES IN DEFINING SOCIAL PROBLEMS AND SOLUTIONS

In the development of the previous outline for suggestions for national uniformity and provision of state role and options, certain key questions were asked in evaluating this proposed major national social legislation:

A. What should be or can be the extent of the national definition of the problem being dealt with and what can be determined and defined only on a state by state basis?

B. What should be or can be the extent of the national prescription of the solution to the problem and require national uniformity and what must rely on state by state determination of the optimum solution to the problem and without national uniformity?

Some of the nationwide variations which must be taken into account are:

Characteristics of the unemployed, present welfare recipients, and low income people.

Average income levels, wages and cost of living in an area or State.

Educational, social or occupational skill levels of welfare and low income individuals in an area or State.

Present extent and organization for delivering public human services in a State.

Availability of private employment or potential public service employment.

Location and mobility of the unemployed in relation to present or potentially available private or public jobs.

Too often the flexibility in federal legislation to deal with state and area differences is provided to the federal administering agency and not to state elected officials. Therefore we are asking that statutory flexibility to deal with state and area variations be instead explicitly provided to state elected officials.

Cash assistance program standards and policies.—We see the need for the federal government to establish some minimum standard for cash assistance which would be fully federally financed and apply throughout the country. Also equity would dictate the need to establish uniform policy on liens on recipients property and the amount of allowable resources in determining eligibility.

However, it is also essential that we recognize the variations in the income levels, wages, and cost of living between States and areas within States. We are therefore suggesting variations in the supplementary payments provision to provide states the option of continuing the practice now in a number of States of distributing part of the assistance payment based on shelter costs and institutional and community care payments. In addition, States which now provide the same payment for an individual whether living as an individual or with their spouse as a couple under the old age assistance program should have the option to continue such a practice.

Work requirements and incentives.—We believe that national uniformity in the establishment of a uniform definition of employability is reasonable.

The present law's provisions regarding that amount of income which may be disregarded in determining eligibility for assistance payments has seen the gross income of families still receiving some payment rise to such levels that the entire program of providing work incentives for low income people has suffered. Thus we are proposing that the States have the option in determining eligibility for state supplementation to apply some gross income limitation at which point a family would no longer be eligible for state supplementary assistance. We are suggesting no less than 150 percent of the State's payment level. It should be pointed out that this is somewhat of a defense against the provision in H.R. 1 which in effect discourages states from making supplementary payments because income disregards are first applied against the federal payment.

Among the options which we feel should be made available to States is flexibility in the use of state supplementary payments to provide incentives for welfare recipients to relocate near available employment. In some cases this may mean providing incentives for a family to move to a rural area where an employment opportunity may exist or is being developed by the State and where living costs such as for housing may be lower.

II. FEDERAL-STATE DIVISION OF RESPONSIBILITY FOR ADMINISTRATION OF CASH ASSISTANCE AND SERVICES

Key questions which must be dealt with in determining the division of responsibility between the federal and state governments for administering cash assistance and manpower, social, rehabilitation, child care, and other related services. These include:

What arrangements can provide the most responsiveness to the needs of the people served and the total electorate?

What arrangements can provide the most efficient administration including the use of the newest administrative procedures and technology?

What arrangements can provide the most effective link and interrelationship among related services?

The following chart illustrates the fragmentation of responsibility for administering cash assistance and services under H.R. 1 compared to provisions in the present law.

X=Proposed responsibilities in H.R. 1; O=Responsibilities under federal law:

	Social Security Administration	Family Benefits Administration	Department of Labor	States
Administering cash assistance for families.....		X		O
Administering cash assistance for aged, blind, and disabled.....	X			O
Administering services:				
Employable heads of families.....			X	(¹)
Families with "unemployable" head of family.....				X, O
Aged, blind, and disabled.....				X, O

¹ Labor Department project grant to State employment service for specific areas in State.

Comprehensive State opportunities for families services plan.—The Administration has indicated that it intends to ask the Congress to appropriate over \$2 billion for manpower training, public service employment, child care and health, rehabilitation and other supportive and social services for the first year of

implementation of the Opportunities for Families Program for employable recipients. The need for these various services vary considerably from state to state according to the characteristics of the recipients and the nature of the job market.

H.R. 1 provides for categorical authorization of funds for each of these services and for the Secretary of Labor to continue to use the categorical project grant approach in funding such services without taking into account efforts by States to coordinate various human service programs. Such a situation would result in further fragmenting the programs which must be interrelated to be effective in assisting people in achieving their fullest self-support potential. Also, the bill has five separate funding authorities related to child care. We believe that each State should submit a Comprehensive State Opportunities for Families Services Plan for a combined funding and coordinated provision of these services to be most responsive to the needs in that State. State elected officials would designate the state agency to administer or supervise the administration of such a plan. The Secretaries of Labor, and Health, Education and Welfare would be required to approve such state plan if it met the requirements of the Act unless they determine that some other unit of government has the capability to more effectively carry out the purposes of the Program and has a greater capability to provide or to enter into arrangement with other appropriate agencies to provide the necessary services.

Senator Louise Conner of Delaware will explain to you some innovative programs in that State for developing public service employment opportunities for welfare recipients and coordinated delivery of services.

State administration of comprehensive social services.—H.R. 1 continues to provide a state role in administration of social services for those defined as "unemployable". However, the bill would deny adequate funding and incentives to states to develop comprehensive social services. Representative Richard Hodes, Chairman of the Health and Rehabilitative Services Committee of the Florida House of Representatives will discuss this matter with you and provide a specific example of a comprehensive one-stop social service project now operating in his state.

Administering cash assistance.—While persistent arguments have been made for the desirability of federal administration of the cash assistance program for both families and the adult categories, the continued state participation in financing the supplementary payments makes it essential that states have the option to administer the cash assistance programs and without the financial penalties in choosing such an option as proposed in H.R. 1. The size and complexity of the federal bureaucracy which would be required and the variations from state to state which would still have to continue plus the sheer size and difficulty of the transition to federal administration would cause very difficult problems.

We do recognize that some increased uniformity in administrative procedures with uniform recipient identification system and uniform data and statistical system that is actually useful for planning and evaluation would be desirable. In addition, federal technical assistance to states to improve administrative procedures and ensure the use of modern technology could provide the advantages of national uniformity without the problems of federal administration.

III. IMPROVING STATES' ABILITY TO LOCATE AND ENFORCE PAYMENT OF CHILD SUPPORT BY ABSENT FATHERS

Major growth of the percentage of families receiving cash assistance payments due to the absence or desertion of the father of the children requires changes in the Social Security Act, improved administrative procedures, and availability of financial resources to enforce payment of support payments by absent fathers. These changes include:

1. Availability without court order of federal agencies information for use in locating fathers who are delinquent in support payments, specifically information from Internal Revenue Service and Veterans Administration.

2. Amendments to the Social Security Act to require mothers to assist in identifying, locating and taking legal action to obtain support from the absent parent.

3. Provide 100% federal financing for state welfare departments to directly hire staff or to contract with other agencies for units of government to assist in carrying out programs of enforcing father support.

4. Provide States the option to experiment with sanctions to enforce the requirement that mothers assist in identifying and locating the absent father.

5. Continue to provide States a proportionate share of the support payment related to the proportion of non-federal share of the cash assistance payment.

Mr. Ben Kain, from the Illinois Department of Public Aid and representing here today the national organization of state officials concerned with administering the interstate compact on enforcement of support has developed a background paper on this issue for the Committee and specific legislative language to amend the Social Security Act.

IV. MEDICAID

We recognize the need to continually improve the utilization review procedures in the Medicaid program to insure that a certain level of care and kind of care is actually needed by patients. However, proposals to reduce federal matching for costs of long-term care now in H.R. 1 are opposed because the time periods are arbitrary, do not recognize medical necessity and would increase costs to states.

V. STATE FISCAL RELIEF PROVISIONS IN H.R. 1

We are aware that various states have made fiscal projections on the impact of H.R. 1 on States that have indicated that even with the hold harmless provisions for cash assistance there may still be significant additional costs to states not covered by the hold harmless provision.

We do not believe it would be politically feasible for states to deny Medicaid coverage to those made newly eligible for cash assistance under H.R. 1. We recommend that H.R. 1 provide a "hold harmless" provision to protect states against increases in Medicaid costs for those made newly eligible for cash assistance programs under H.R. 1.

State fiscal relief provisions in H.R. 1 should be amended to provide federal participation in the cost to a state of (1) maintaining present levels of support and (2) increasing payment levels to reflect cost of living increases.

We also support proposed amendments to H.R. 1 to provide emergency and retroactive fiscal relief for States from welfare costs.

IMPROVING STATE ABILITY TO LOCATE AND ENFORCE PAYMENT OF CHILD SUPPORT BY ABSENT FATHERS

Memorandum from National Conference on Uniform Reciprocal Enforcement of Support to Senate Finance and House Ways and Means Committee Considering Amendments to the Social Security Act, Including HR 1.

The National Conference on Uniform Reciprocal Enforcement of Support, composed of judges, masters, referees, clerks, probation officers, various other court officials, local prosecutors, state attorney general representatives, welfare administrators, social workers and the like, wishes to bring several matters of general concern to the attention of the Committee for its consideration.

Of utmost concern are the several federal district court decisions holding the granting of AFDC benefits may not be conditioned upon the cooperation of the mother, or other custodial relative, with welfare department or law enforcement officials in obtaining support for the child(ren) from an absent parent. These decisions have been affirmed by the United States Supreme Court in *Juras v. Meyers*, No. 71-63 (Oregon) and *Weaver v. Doe*, No. 71-478 (Illinois) and apply whether the child is born in or out-of-wedlock.

The so-called "NOLEO" provisions of the early '50s requiring that prompt notice be given the local law enforcement official of the furnishing of aid to a child who has been deserted or abandoned by a parent, the requirement in the early '60s that each state establish a central unit for location purposes, the 1967 Social Security Amendments requiring a single unit for obtaining support from an absent parent, including establishing paternity when necessary and federal participation in the special funding of these efforts, seem to express clear congressional intent. Under today's law, the mother is excluded from this cooperative effort.

In order to implement these requirements effectively, many, if not most, states have required the cooperation of the mother, or other custodial relative, as a condition of eligibility for the child(ren) for whom a duty of support is owed. For a child born out-of-wedlock, the mother is the only person who can name the father, sign the paternity complaint, and testify to material facts.

While it is true some states have Statutes enabling the welfare department to bring an action in its own name to obtain support from the absent parent of a child born in wedlock or whose paternity has been established, usually the only evidence it can present from case files regarding desertion and non-support is self serving and second hand. Law enforcement officials and courts customarily require testimony of a witness having first-hand knowledge of the circumstances and the action, being civil in nature, does not carry the usually sanctions of the non-support misdemeanor. We hasten to point out, cooperation is needed to obtain the address of all types of absent parents or leads upon which to base location effort.

Although the proposed disregard of a portion of the income from support payments in arriving at need will serve as an incentive in some cases, there seems to be little justification for not taking appropriate support action in all cases where possible.

The Conference urges strong federal sanctions be enacted as soon as possible by amendment of the Social Security Act requiring full recipient cooperation in every material aspect of the support enforcement process as a condition of initial or continuing eligibility for AFDC. Without such sanctions, Conference members feel cooperation will be minimal, rising caseloads with decreasing support contributions will result, and an effective test of whether or not there is a bona fide desertion under current federal law will be lost.

Self-incrimination, right to privacy, equal protection and the imposition of an additional eligibility requirement by the states not required by the Social Security Act have been the issues raised in the federal court cases. The courts have not reached the Constitutional objections in their decisions.

Sanctions contained in Social Security Act amendment could be waived in the event criminal prosecution for adultery or fornication were possible under state or local law. Those few states having such laws could then grant immunity from prosecution by legislative amendment where such information was obtained for support purposes in welfare cases or abolish the criminal Statutes altogether in accordance with current trends. There seems to be some favorable precedent with regard to the privacy issue, leaving only a possible attack on grounds of equal protection.

The Conference is of the opinion principal responsibility for support and fraud prosecution should be left with the various states under existing laws and collection procedures. Under present federal and state law, there is appropriate sharing of the proceeds of on-going support money, reimbursement of assistance granted, or money obtained by fraud prosecution.

However, more equitable and definite arrangements for sharing of the proceeds of support and fraud action need be established under HR 1 and other Social Security Act amendments. States supplementing the federal minimum income allowance should share on a proportionate basis.

In the event S. 3019 is adopted by the Congress, Attorney General actions likely will be relatively few in number since most absent parents reside in the state where assistance is granted, a number of mothers have been the persons traveling in interstate commerce and, in many instances, paternity has not been established. Sharing of any recovery with the state, however, should not be conditioned upon a prior state court order. Personal service for ordering support normally is required and not possible when the whereabouts of the absent parent is unknown.

The Conference urges Congress make funds more readily available for the law enforcement process for obtaining support. Although funds are currently available for welfare department support activity, salaries and fees for prosecuting attorneys, courts, clerks, sheriffs, and the like, are furnished from state and local funds, with the federal government sharing in the proceeds.

Matching funds are available currently for selected demonstration projects involving arrangements with local courts and law enforcement officials supplying other than usual service to the welfare agencies. Reported projects seem to be limited to assumption of welfare agency responsibilities for which funds were already available with little, if any, net increase in money to the states.

Lastly, the Conference believes information should be available to state locator services in welfare cases from all federal agencies, including the Veterans Administration from which no information may be obtained at this time. Address information from Internal Revenue Service should be available without the necessity of a prior court order, as in the case of the Social Security Administration.

Section 402(a)(17) of the Social Security Act is amended by striking the semicolon at the end thereof and substituting a comma and the word "and", and by adding the following new subparagraph:

"(C) that if and for so long as—

(i) a mother who has in her care a child referred to in clause (A) (i) refuses to identify the father of such child and to participate in establishing the child's paternity and securing support for him, and

(ii) a mother or other relative having in her or his care a child referred to in clause (A) (ii) refuses to supply information to aid in locating the deserting or abandoning parent and to participate in obtaining support from such parent.

such mother's or other relative's needs shall not be taken into account in making a determination under clause (7), and aid for any dependent child in the family in the form of payments of the type described in section 406(b)(2) (which in such cases shall be without regard to clauses (A) through (E) thereof) or section 408 will be made; except that the provisions of this clause (C) shall not apply to a mother of a child born out-of-wedlock if her identifying the father of such child would subject her to criminal prosecution under State laws or local ordinances pertaining to adultery or fornication, and the State agency shall for a period of sixty days make payments of the type described in section 406(b)(2) (without regard to clauses (A) through (E) thereof) on behalf of the mother or other relative having charge of the child if during such period such mother or other relative accepts counseling or other services aimed at persuading such mother or other relative to participate in obtaining support for the child;"

Mr. DINES. Mr. Chairman, we have with us, just arrived, Senator Louise Conner from Delaware and, if you have a few minutes, we had planned to ask her to tell you about a program in Delaware that I think would be of particular interest to you. I don't know if your time permits that now or not.

Senator ANDERSON. We started off with all we can do, but go ahead.

STATEMENT OF HON. LOUISE T. CONNER, STATE SENATOR FROM DELAWARE; ACCOMPANIED BY ARVA JACKSON, AIDE TO GOV. RUSSELL W. PETERSON OF DELAWARE

Mrs. CONNER. All right; thank you, gentlemen. I am sorry we were late, we were delayed and we very much appreciate this opportunity. I have with me today Mrs. Arva Jackson, who is an aide to Gov. Russell Peterson of Delaware, and the Governor has been very innovative in this field.

In our State we have tried to do the best we can within the categorical grants to have integrated programs and cross-division and department lines in order to get our people in State government working together, and we have developed two or three quite innovative programs.

The first one I am going to talk about very briefly is the something for something program and obviously this is a play on words something for nothing. What we have tried to do in that program, which was developed only a year ago, is to take adults and children for whom it is feasible to promote movement to economic self-sufficiency, and for those for whom economic self-sufficiency won't work, to get them working as much as we can, so that they have the feeling that they are making a worthwhile contribution to society and not just getting a dole.

In lieu of a grant check moneys are paid for training experiences for welfare recipients who are assigned within the department of health

and social services. A check in the amount of \$281 gross per month per employee-trainee is received. Most of the employee-trainees in the something for something program have been put in human service slots. They have been given jobs in our hospital for the mentally retarded, the Delaware State Hospital, Ferris School for Boys, the Family Court, vocational rehabilitation centers, and the thought has been to take these people and pay them very little less than the minimum that is paid people in the State government, so that we don't get into trouble with the unions, and to put them in slots where they can help provide State services, and we have found that they are particularly adapted in human services, for example, someone working at the State hospital who might have a real feel for working with people, and might need a little training, and they have been used in this way, and been given the feeling that they are people who really amount to something because they are giving a real service to the State and not just getting a deal, and that is what was behind the something for something program.

Another one of our main programs has been the Delaware Joint Action Plan which we just put, gave legislative implementation within the last week, and the purpose behind this program is to take general assistance recipients who, for the most part, do not have families, and to get them, get the notion to them, that they are not going to get their relief payment if they turn down a job, so they are offered a job, and they are sent over to vocational rehabilitation to get some training. Then if they won't participate in any of these efforts to upgrade them it is made very clear to them they don't get their checks, their relief checks, in this program. We are actually applying a little bit of force, and giving them a little extra push and saying to them, "If you really want to amount to something you can't just stay forever on the dole but you have to be willing to go to work, be willing to upgrade yourself and take some vocational training."

Now, we also have had in Delaware the WIN program, which I don't have to explain to you gentlemen because you understand about it, and we have had a TV program which has had a whole lot of work on it and it has to do with vocational rehabilitation of public assistance recipients, and again this was envisioned about a year ago, the first prospectus was written on it, and in the meantime they have really been struggling to make it fly, and there have been the usual difficulties you have when you have got something creative and innovative going and when you are reaching across division and department lines, you have got the department of labor and the department of health and social services involved here and they have had to learn to work with each other and to be creative and cut redtape, but again we have had progress.

In the papers that we will turn in to you, which we hope you will read, there are figures telling how well we have done with this program.

All in all, I think that the State of Delaware under Governor Peterson has been showing real creativity and a sense of purpose in trying to make people understand that in order to be worthwhile citizens they must do their level best to make a contribution, and we have done everything we can to upgrade them vocationally and to make them, make a worthwhile contribution.

Senator TALMADGE. May I ask a question at that point?

Mrs. CONNER. Right.

Senator TALMADGE. Have you done any experimentation in the State of Delaware with AFDC mothers serving in child care centers looking after the children of their neighbors so they could work?

Mrs. CONNER. I think that Mrs. Jackson can give you more facts on that than I can. We have particularly in our something for something program been concerned with the ADC mothers.

Mrs. JACKSON. Yes, I would be glad to. As a matter of fact, this is an idea we considered when the something for something program was developed. We had difficulty working out a funding mechanism that was acceptable, so we have started by using those AFDC mothers who are the ones in the something for something program in State agencies. We will soon be moving them into private agencies, and it is anticipated that we will be able to work out a system so that they might be established as day care mothers and be able to care for the children of other AFDC mothers and will then be released to go to work using this mechanism.

Senator TALMADGE. It looks like to me this would be an ideal system because they normally live in the same neighborhood and frequently they are acquainted personally, and if you could pick out the best-informed woman in the community to take care of the children of several of her neighbors, that would free them to work, and I think that ought to be a very good solution to some of the problems involving day care.

Mr. HODES. May I make a comment on that, Senator? In the city of Tampa's model cities program, this was developed very carefully, using day care centers and using AFDC mothers and training them as public service employees. By and large, it is a fair program. It has some great defects because quality day care requires some training and a certain amount of interest and being consistent in attending to the job, and just getting people to show up for work is a very difficult thing to do. Currently, we don't have any mechanism for making AFDC payments contingent upon that particular activity.

Senator TALMADGE. Would you recommend we write such a mechanism into this bill?

Mr. HODES. I am not certain but that it wouldn't be a good idea, that if employment is available and people are trained for the job—now, of course, they may not be trained.

Senator TALMADGE. No, but they would be as well trained as the mothers in the community that are looking after them now, wouldn't they?

Mr. HODES. No question about it. In fact, there are people that we tried to get in the program, who are doing some babysitting at home, and yet when we tried to get them to work in the day care center, they had already taken care of children, they would somehow develop an extraordinary incapability of taking care of children in a day care center. It is very startling how that will arise every once in a while.

The CHAIRMAN (presiding). Well, now let me ask you this about an approach. Supposing we said to a State and a community that, "We will provide two kinds of matching, we will just continue to give you what you are getting now, if you want to pay people for income maintenance, but if you want to pay them to do something, just anything that you think is worthwhile, marginal though it may be, we will give

you better matching. For example, we will give you 50-50 matching if you have more than the average income in your State, give you 50-50 matching for income maintenance purposes, for what you presently call the AFDC. If you want to put that mother doing something, we will give you 2 for 1, we will give you $66\frac{2}{3}$ rather than 50-50, so you get 2-for-1 matching if you are paying people to do something. But you get only 50-50 matching insofar as you are paying income maintenance."

If you could then get your money freed by the legislature so you can use it either way, and in many instances it wouldn't require an act of the legislature, so you could do it either way, so you could either do income maintenance or you could pay for work, wouldn't that provide you with an incentive?

I see this lady here wants to add something to it.

Mrs. JACKSON. I want to add to that. Actually, that machinery really exists now. If you use the State's share of the AFDC grant and match it with title IV(A) money of the Social Security Act you can get a 75-25 matching, use it that way.

The CHAIRMAN. Don't say IV(A) because you are talking like a technician; put it in layman's language.

Mrs. JACKSON. It is the purchase of services that any division of social services or department of welfare can use once they have determined services they will purchase. That is usually the only State agency that can use that matching formula, but if they choose to use their State appropriation that way, and this is what we have done in the something for something program, we are able to get the best use of that money and pay people for doing those kinds of human services jobs. That is precisely what our something for something program does.

The CHAIRMAN. Well, there are just a lot of things people can do. Governor Reagan suggested that one of the type things that would be worth paying for would be in the area where you have had your school buildings vandalized—just pay somebody to keep an eye on the school building. Now, a person can take the child along with them. The child can play with other children right on the school grounds, and hopefully they might pick up some of the litter that might be laying down there and help to tidy the place up a bit. That is not hard work; and, at the same time, if you get far more favorable matching with your money then on that program you could pay them a lot more for that than you can for just sitting at home, and it gives a person a feeling of usefulness in doing that. They are doing something and doing a useful job for this society of ours, not just living on a dole somewhere.

Mrs. CONNER. Exactly.

Senator, if I may, I would like to give you a very short list here of the State agencies that are using at least one something for something employee: Our State hospital for the mentally retarded; Delaware State Hospital; our school for boys, delinquent boys; our family court has four and will take two more; our vocational rehabilitation centers are using five of them; division of social services, 12; and our delinquent school for girls is using one. These are all people, AFDC mothers instead of just getting a grant are doing something, making something of themselves and making a contribution to the State government in human services.

Senator TALMADGE. If you will yield, Mr. Chairman, what percentage have you enrolled in your something for something program?

Mrs. CONNER. A very small percentage, because this whole thing is, we have only had a year to get it going.

Senator TALMADGE. Would it be 1 percent, 2, 5 or less?

Mrs. CONNER. More like 1, I would say.

Senator TALMADGE. One percent.

Mrs. CONNER. Right.

Senator TALMADGE. That is at least a start.

Mrs. CONNER. It is at least a start, that is right, and the legislature, we have tried to be as cooperative as we could here, and give enabling legislation to make these things go.

The CHAIRMAN. Any further questions?

Well, permit me to say something for something makes twice as much sense to me as something for nothing.

Thank you very much.

Mrs. CONNER. Thank you very much for this opportunity.

(The prepared statement with attachments of Mrs. Conner follows:)

PREPARED STATEMENT OF STATE SENATOR LOUISE T. CONNER, CHAIRMAN OF HEALTH AND SOCIAL SERVICES COMMITTEE OF STATE SENATE, AND MRS. ARVA JACKSON, AIDE TO GOVERNOR RUSSELL W. PETERSON

The State of Delaware recognizes the need for creativity in designing programs to help people to help themselves.

In an attempt to experiment with diverse self-support efforts the following programs are being carried out:

- I. Something for Something.
- II. Vocational Rehabilitation Social Services Project.
- III. Work Incentive Program (WIN).
- IV. Joint Action Plans.

REPORT TO ADVISORY COMMITTEE ON THE VOCATIONAL REHABILITATION OF PUBLIC ASSISTANCE RECIPIENTS, JANUARY 17, 1972

OVERVIEW

During the first six months of operation of this program, primary effort has been devoted to physical facilities, staffing, and staff orientation and training. An effort of this scope, especially one that deliberately sought to cross traditional agency and professional boundaries, has had and will continue to have a wide variety of developmental problems. Nonetheless, the program is beginning to operate essentially as it was envisioned and authorized. Except for one office which has experienced some real difficulty in becoming established, all units appear to be functioning satisfactorily except for the problems that are outlined below. Of special interest is the fact that there seems to be very little internal difficulty with the dual role assigned to each discipline within the concept of integration of services. Externally, however, it is sometimes difficult to separate broad concepts of agency role from that of integrated delivery of social, employment, and rehabilitation services to an individual.

Caseload statistics

Total public assistance recipients: July to December, 1971-----	1821
Current cases: In evaluation status (includes 53 in trial services to determine feasibility)-----	1079
In-service status (includes 13 ready for employment and 53 in employment)-----	569
Cases closed since July:	
Not accepted-----	116
Not feasible after trial services-----	6
Rehabilitated-----	24
Closed unemployed-----	27
Total closed-----	173

EVALUATION

An objective of the program as originally envisioned was to develop the capacity to complete an initial evaluation of a client within one week of the first contact. While the development of the technical capacity to do this is progressing satisfactorily, staffing has been and remains a critical problem. With the objective of utilizing carefully trained paraprofessional persons from minority backgrounds to administer the evaluation instruments, we have interviewed and tested over 80 applicants for these positions, including a special list of some 60 persons identified by the Director of Personnel as eligible for the position of "Neighborhood Worker." Despite these efforts, three of the positions currently remain unfilled, and most of the other eleven have only recently been filled.

The practical result of this problem is that some of our units are now scheduling as much as six weeks in advance for necessary evaluations. Use of private psychologists and physicians has also reached a saturation level. Efforts are underway to recruit hospital residents and additional psychological and psychometric personnel to handle the mounting backlog of persons.

DELAWARE PROGRAMS

"SOMETHING FOR SOMETHING" PROGRAM

Goals (developed February 1971).—

1. For those adults and children for whom it is feasible: to promote movement to economic self-sufficiency.

2. For those for whom economic self-sufficiency is not feasible: to maintain their maximum independence, self-determination, and to lessen their isolation.

Status.—Currently there are 26 trainees in this program. It is anticipated that the Vocational Rehabilitation Centers will select 28 more, for the 14 centers by February 1972. Family Court has employed two (2) trainees to begin work effective January 1. They will hire four (4) more soon. Three (3) trainees will help in our Protective Services Program. By February 1, there should be a total of approximately 60 trainees.

Cost.—In lieu of a grant check monies are paid for training experiences for welfare recipients who are assigned within the Department of Health and Social Services. A check in the amount of \$281 gross per month per "employee-trainee" is received. ($\$281 \times 200$ (projected no. of trainees per month) = \$56,200) when program is fully operative.

Most of the employee-trainees are in Human Services job slots. All are at Pay Grade 2 (\$281/month)—a grade just below the lowest pay grade for regular state employees.

Currently (at least one SFS employee-trainee).—

Delaware Hospital for the Mentally Retarded.

Delaware State Hospital.

Ferris School for Boys.

Family Court—4 (will take 2 more).

Vocational Rehabilitation Centers—5.

Division of Social Services—12.

Woodshaven-Kruse School for Girls.

Proposed Geriatric Services (private).—

Plans to take 20.

Estimates they can take 200.

The State's share of AFDC money is used to match Title IV-A money on a 75-25 ratio.

We provide group coverage by Blue Cross (via transfer Medicaid funds) and Day Care.

JOINT ACTION PLAN

Goals.—To remove general assistance recipients who have been identified as employable from the welfare caseloads and to provide concentrated and coordinated services in order to provide them with employment and/or rehabilitative preparation for employment.

Target Population.—2,143 recipients between the ages of 18 and 54 years who have identified by the Division of Social Services as employable (1530) or potentially employable (613).

Current Status.—With the issuance of the February grant 1530 employable recipients will have been advised that they are being referred to the Division of

Employment Services for job counseling and that their case is being discontinued by the Division of Social Services.

In a similar manner 613 potentially employable recipients will have been advised that they are being referred to the Division of Vocational Rehabilitation for services and that their case is being discontinued by the Division of Social Services. In addition, the Division of Employment Services will assign an Employment Counselor to the intake section of Region I Office of the Division of Social Services by January 10, 1972. All persons applying for assistance as of that date will be screened to determine whether they are applying for one of the following reasons:

- (1) They are employable but are applying because of loss of employment;
- (2) They are applying because of exhaustion of resources and are employable;
- (3) They have exhausted their unemployment compensation benefits and are employable. If the applicant meets any of these three stipulations, he will be referred immediately to the Employment Counselor and no (fiscal) assistance will be granted.

In addition, joint exploration will be made by the staff of the Department of Labor and Department of Health and Social Services toward the feasibility of transferring all or part of the administrative responsibility for the General Assistance Program from the Division of Social Services to the Department of Labor and/or a redefinition of eligibility for this program regardless of the administrative or organizational pattern.

The CHAIRMAN. The next witness is Mr. Richard M. Loughery, administrator of the Washington Hospital Center, accompanied by Kenneth Williamson, director of the Washington Service Bureau, American Hospital Association. Will you proceed, sir?

STATEMENT OF RICHARD M. LOUGHERY, ADMINISTRATOR, WASHINGTON HOSPITAL CENTER, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION, AND DIRECTOR, WASHINGTON SERVICE BUREAU

Mr. LOUGHERY. Thank you, sir.

Mr. Chairman, I am Richard M. Loughery, administrator of the Washington Hospital Center here in the District of Columbia, and I appear today on behalf of the American Hospital Association which represents some 7,000 hospitals of the Nation. I am accompanied by Mr. Kenneth Williamson, deputy director of the American Hospital Association and director of its Washington Service Bureau.

We appreciate this opportunity to present to the committee the issues which give us concern in H.R. 1. I have a full statement which I would like to submit for the record. But because of the limitations of time, I shall speak only about two key aspects which the hospitals feel might impair their very existence.

First, the problem of hospitals, unrecovered community service costs. One of the major concerns of the hospital field—and we have discussed this with the committee in the past—is the failure of the medicare program in its capacity as the payer for hospital services provided medicare patients to participants in meeting the full cost of hospitals' community services on the same basis as other payers for similar services. The Government excluded from medicare reimbursement the cost of the hospital's community services. These include such items as unrecovered costs due to nonpaying patients, charity services and deficits from contractual arrangements, together with growth and develop-

ment costs. These costs must be borne by other patients and this is patently inequitable.

In our past testimony before this committee, we presented results of a 2-year study on the part of the hospital field of a new basis or reimbursement to meet the full financial requirements of health care institutions and which related reimbursement to planning control. This study resulted in the adoption by the association of a financial policy statement, "The Statement on the Financial Requirements of Health Care Institutions and Services." A copy of this has been provided in the past to each member of the committee.

The policy statement has been accepted by the hospitals of the Nation as a basis for establishing rates for all purchasers of hospital services—individuals and third party payers, including the Government. We believe the financing of institutional health care should include several items.

1. The institution's responsibilities to the community;
2. The need for systematic financing of all their operating and capital needs;
3. A rationale for proper planning of facilities and services;
4. Incentives for economy and efficiency in the delivery of high quality health care; and
5. The necessity for the maintenance of quality and the protection of the interests of both provider and purchaser. These financing principles take cognizance of the differences between the institutional health care system and the rest of the economy. In the free market, industry can alter either the nature or the quality of its products or it might discontinue a product in order to assure that current revenues are adequate to meet operating and capital needs. If the quality and scope of health services are to be maintained, health care institutions cannot be allowed these same options. The prices established through bargaining between individual providers and large groups of purchasers must provide revenues that are sufficient to finance these services.

Because of the significant problems created by nonpaying patients; because of the necessity to maintain standby services; and because of the cost involved in meeting the educational responsibilities of health care institutions, hospitals find that the limited capital payments that are currently included in contractual reimbursement agreements often must be diverted toward meeting operating expenses. Thus, the health care system has had increasing difficulty in maintaining and expanding its capital financing.

The association's "Statement on Financial Requirements" provides that all payers of health care including direct pay patients and all third party payers shall contribute to the total financing of the community hospital on a fair and equitable basis.

To help accomplish this and have the Federal Government accept its full responsibility to the hospitals of the country for care provided to Medicare patients, we again recommend that the act be changed to redefine, reasonable cost to include total community health care costs—to be shared equally by all payers for hospital services. Specific language to accomplish this is contained in our statement.

Mr. Chairman, to put this in perspective let me tell you the effect the failure of the Government to share in these unrecovered costs has at my hospital.

In our institution medicare represents 23 percent of our total business and medicaid an additional 8 percent, or a total for those Government programs of 31 percent of our total volume.

Last year our nonpaying patients, the bad debts, amounting to \$1.8 million and my charity work and less than cost services to indigent patients under an agreement with the District of Columbia, cost us \$1 million. Thirty-one percent of these amounts—not recoverable from the medicare and medicaid programs—is about a million dollars. Add to this a 4-percent factor for growth and development which the Government doesn't recognize and we have about \$1.5 million which must be recovered from paying patients who are already paying their fair share of these costs, but we have to overprice the services to them by more than \$6 per day they are in the hospital. I have a statement prepared by our accounting department documenting these costs and I will be pleased to make this a part of the record.

Now, the second phase——

Senator CURTIS. May I ask you a question?

Mr. LOUGHERY. Yes, sir.

Senator CURTIS. Is there anybody else besides the Government who pays a hospital on what is determined are reasonable costs?

Mr. LOUGHERY. By other patients, sir, do you mean a private-paying patient?

Senator CURTIS. Yes, or an insurance company or anybody else.

Mr. LOUGHERY. Yes. These people all pay their own cost.

Senator CURTIS. No, no, here is what I want to know—is there anybody's billing that is handled by medicare and medicaid?

Mr. LOUGHERY. Most of the Blue plans are, sir.

Senator CURTIS. The Blue plans.

Mr. LOUGHERY. Yes, sir.

Senator CURTIS. Based upon what it costs the hospital?

Mr. LOUGHERY. Yes, sir.

Senator CURTIS. There are no private insurance companies that do that?

Mr. LOUGHERY. No, sir. That is because most of the private companies are on an indemnity basis. They pay billings.

Senator CURTIS. How much money do all the hospitals spend in trying to submit and prove what the reasonable costs are?

Mr. LOUGHERY. An inordinate amount, sir.

Senator CURTIS. How much money does the Government spend running around checking hospitals and disputing items as to what was a reasonable cost?

Mr. LOUGHERY. I would have no idea as to the Government's expenditure for these audits of the various formulas.

Senator CURTIS. I think it is a terrible system and I find in my State there may be a rural hospital that is well run, and the patients get well. I guess that is what a hospital is for, I suppose, and they may have a daily rate of \$40, and they will be harassed and punished as much to prove that they should be paid \$40 as another hospital whose rate is \$80 and I can't figure it out other than it is make-work for the Government.

Mr. LOUGHERY. Well, sir, one of the problems on this I presume we have a responsibility to the public to prove our costs. If there were only one formula to be followed it wouldn't be so bad.

Senator CURTIS. No, but we shouldn't take a great portion of the hospital's budget or the Government's to do the paperwork.

Mr. LOUGHERY. Senator Curtis, I am totally in sympathy with you, but I don't know how to accomplish that. There is an inordinate amount of time that is spent in justifying and reproving what our public accounting firm, the outside auditors, have already stated.

Senator CURTIS. They don't take anybody's word for it?

Mr. LOUGHERY. No, sir.

Senator CURTIS. They don't take anybody's word for it. Yet it is taking money that was intended to help people to pay their expenses of illness for an outside exercise that doesn't serve any purpose whatever and does not save money for the Government.

Senator NELSON. May I ask a question along that line?

Mr. LOUGHERY. Yes, sir.

Senator NELSON. Do I understand your testimony to be that your hospital must charge \$6 a day additional in order to offset the losses, so to speak, that the hospital experiences from medicare and medicaid patients not assuming their full costs?

Mr. LOUGHERY. That is correct, Senator Nelson. The reimbursement formula does not recognize community services. The formula is restrictive in that it rules out things that must be provided to all patients, such as there is a certain—for instance, obstetrics, no medicare patient, by and large, needs obstetric services. The cost of the obstetric department is not considered in establishing the medicare reimbursements formula.

Senator NELSON. Do you charge every patient who uses the same facilities in the hospital the same price except the medicare and medicaid patient?

Mr. LOUGHERY. That is correct, in general. There are many patients who cannot meet their bills. Medicare and medicaid will assume no portion of those unpaid bills, whereas you or anyone else as a paying patient has to pick up that slack. This is the community service that is not covered.

Senator NELSON. Thank you.

Senator CURTIS. I don't want to take too much time but I have one more question. Do you have an interest expense because you are waiting for the Government to reimburse you?

Mr. LOUGHERY. No, sir. This is one of the reasons in our institution that we have a growth and development fund. It would be the same as we have to use a reserve while we are waiting for various third parties to pay their bills but we do not have commercial loans. I do know, in answer to your question—

Senator CURTIS. Would your reserve be invested?

Mr. LOUGHERY. Yes, sir, without question, but I do know, in direct answer to your question, that this has happened to many institutions.

Senator CURTIS. Yes, I know a hospital run by a church which has had to pay interest on about \$300,000 some years.

Mr. LOUGHERY. Yes, sir.

Senator CURTIS. While Government auditors fiddle with their pencils. It is a bad system. I don't mean to reflect on the individual in-

volved in auditing, not at all, but I think we have to work out something different.

Mr. LOUGHERY. There are mechanics, I believe, that are available. I am sure the American Hospital Association would be glad to counsel with the appropriate parties as to how this could be helped.

The determination of reasonable hospital costs under medicaid, undoubtedly, the item of greater concern in H.R. 1 to the health field and which we believe potentially would have the greatest adverse effect on the quality and availability of patient care, is section 232. This section would authorize States to develop their own methods and standards for payment of reasonable costs for inpatient hospital care under the medicaid and maternal and child health programs.

Since the very inception of the medicare and medicaid programs in 1966, tremendous effort has been expended by the hospital field and by the Federal Government to provide for uniform cost findings, records, and billings. This is directly what you were asking, Senator Curtis. This effort has avoided expenditures which otherwise would have been required to develop cost finding systems to comply with different reimbursement formulas. Certainly, if section 232 is enacted, it will eliminate the benefit of the substantial progress that has been made to simplify the accounting involved in titles XVIII and XIX. Further, it would nullify the potential for simplification and coordination of the administration of these titles. It would be a backward step which would inevitably increase the costs of administration of these programs.

It is our understanding that this proposal was put forth by the States to reduce expenditures. Since section 232 would prohibit reimbursement in excess of the medicare formula, it can only be intended to allow States to pay hospitals less for services provided medicaid patients than the Social Security Administration has determined to be fair and reasonable under the medicare formula.

As I pointed out earlier the medicare formula does not even now require the Federal Government to pay a fair share of support for the community hospitals. Certainly, any proposal which would permit the States to pay even less than costs as determined under the medicare formula would be completely inequitable and unfair to hospitalized patients.

There can be only two likely results from the inaction of enactment of 232. Hospitals will either have to reduce the number of poor and near poor patients for whom they can provide services or the Federal Government will have to provide some form of subsidy to keep hospitals from bankruptcy. The number of private paying patients to whom hospitals must turn to recover their unreimbursed community service costs is an extremely small number of people. If this amendment is passed, the total amount of unrecovered costs will be increased and hospitals will be forced to "Robin Hood" these costs from a dwindling group of other patients, thus creating for them an intolerable burden.

Mr. Chairman, you may recall that my hospital recently announced a reduction in its rates. We reduced our rates \$11 per patient-day which on an annual basis amounts to \$1.7 million; 80 percent of this reduction was made possible by the institution of a medicaid program in the District of Columbia under which hospitals are now being paid costs as determined under the medicare formula for care provided the

poor and near poor. Prior to the District of Columbia medicaid program we were being paid substantially less than half of our costs for care provided indigent patients and my hospital's deficit from such indigent care had to be "Robin Hooded" from our paying patients to the tune of an additional \$8 or \$9 a day.

Frankly, gentlemen, our field has great difficulty in comprehending the rationale of legislation by which the Federal Government would on the one hand, authorize States to pay less than cost as determined under the medicare formula for the care of medicaid patients; and on the other hand, refuse under the medicare program, to pay any share of the deficiency arising from such "less than cost" services.

We strongly urge that the committee delete section 232 from the bill.

Mr. Chairman, hospitals are fully cognizant and understanding of the concern of the Government in respect to the cost of hospital care and recognize the need for controlling these costs. A number of provisions in H.R. 1 are designed to accomplish this purpose and we are in general agreement with many of them.

We believe that a major improvement in the delivery and financing of health care is necessary in order to provide comprehensive care in the most economic and efficient manner possible. The American Hospital Association has invested extensive resources in basic studies and in the development of guiding principles to accomplish this goal. We presented our recommendations in the matter to this committee in April of last year and to the House Ways and Means Committee last November in the course of hearings on the subject of national health insurance.

We are making every effort to bring about planning controls so as to assure that neither health facilities nor services can be developed or operated unless it can be demonstrated that they are needed by the community.

We are exerting efforts to bring about the development or rate review mechanisms or agencies at the State level which must sanction any changes in hospital rates. In essence this would require all hospitals to justify their rates.

Further, we strongly support experiments and demonstration projects that would involve reimbursement to hospitals on the basis of prospective rates. This would require individual hospitals to work within a prospectively approved budget in contrast to the present method of reimbursement which is largely on a retrospective basis.

Accomplishment of several of these goals will require Federal financial support for experiments and demonstrations and we are pleased to note H.R. 1 contains provisions authorizing such financial assistance.

Mr. Chairman, the statement I have submitted contains specific recommendations on a number of other provisions in H.R. 1. On behalf of the hospitals of the Nation and of the patients and communities they serve, we ask the committee's earnest consideration of these recommendations which I have not discussed only because of the time limitation for my presentation.

Again, we appreciate this opportunity to present these views of the American Hospital Association and we will be pleased to answer any questions or provide any additional information we can to the committee.

Thank you.

Senator ANDERSON (presiding). Thank you for a very fine statement. (Prepared statement and attachments of Mr. Loughery follow. Hearing continues on p. 2288.)

PREPARED STATEMENT OF RICHARD M. LOUGHERY, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Richard M. Loughery, Administrator of the Washington Hospital Center here in the District of Columbia, and I appear today on behalf of the American Hospital Association which represents some 7000 hospitals of the nation. I am accompanied by Mr. Kenneth Williamson, Deputy Director of the American Hospital Association and Director of its Washington Service Bureau.

We appreciate this opportunity to present to the committee the issues which give us concern in H.R. 1.

The Problem of Hospitals' Unrecovered Community Service Costs. One of the major concerns of the hospital field—and we have discussed this with the committee in the past—is the failure of the Medicare program in its capacity as the payer for hospital services provided Medicare patients to participate in meeting the full cost of hospitals' community services on the same basis as other payers for similar services. The government excluded from Medicare reimbursement the cost of the hospital's community services. These include such items as unrecovered costs due to non-paying patients, charity services and deficits from contractual arrangements, together with growth and development costs. These costs must be borne by other patients and this is patently inequitable.

In our past testimony before this committee, we presented results of a two year study on the part of the hospital field of a new basis of reimbursement to meet the full financial requirements of health care institutions and which related reimbursement to planning controls. This study resulted in the adoption by the Association of a financial policy statement, "The Statement on the Financial Requirements of Health Care Institutions and Services." A copy of this has been provided in the past to each member of the committee.

The policy statement has been accepted by the hospitals of the nation as a basis for establishing rates for all purchasers of hospital services—individuals and third party payers, including the government. We believe the financing of institutional health care should recognize:

1. The institution's responsibilities to the community;
2. The need for systematic financing of all their operating and capital needs;
3. A rationale for proper planning of facilities and services;
4. Incentives for economy and efficiency in the delivery of high quality health care; and,
5. The necessity for the maintenance of quality and the protection of the interests of both provider and purchaser.

These financing principles take cognizance of the differences between the institutional health care system and the rest of the economy. In the free market, industry can alter either the nature or the quality of its products or discontinue a product in order to assure that current revenues are adequate to meet operating and capital needs. If the quality and scope of health services are to be maintained, health care institutions cannot be allowed these same options. The prices established through bargaining between individual providers and large groups of purchasers must provide revenues that are sufficient to finance these services.

Because of the significant problems created by non-paying patients; because of the necessity to maintain standby services; and because of the cost involved in meeting the educational responsibilities of health care institutions, hospitals find that the limited capital payments that are currently included in contractual reimbursement agreements often must be diverted toward meeting operating expenses. Thus, the health care system has had increasing difficulty in maintaining and expanding its capital financing.

The Association's "Statement on Financial Requirements" provides that all payers of health care including direct pay patients and all third party payers shall contribute to the total financing of the community hospital system on a fair and equitable basis.

To accomplish this and thus have the Federal Government accept its full responsibility to the hospitals of the country for care provided to Medicare patients, we again recommend that the language of Section 1861 (v) (c) of Public Law 89-97 be revised as follows:

1. Delete clause (A) of the fourth sentence of such section, and substitute therefore the following:

"(A) take into account both direct and indirect costs of providers of services, provided, however, that the costs of new construction or expansion and that the cost of providing new services shall not be included unless such new construction, expansion or new service shall have been approved in advance by the designated area-wide planning agency."

2. "The term 'reasonable cost' as used in this law shall mean the total monetary resources that a health care institution or service needs or will need to fulfill its role in meeting community health service objectives. The Federal Government's share of these financial requirements for its beneficiaries shall not be more than nor less than the share borne by all other paying patients."

DETERMINATION OF REASONABLE HOSPITAL COSTS UNDER MEDICAID

Undoubtedly, the item of greatest concern in H.R. 1 to the health field and which we believe potentially would have the greatest adverse effect on the quality and availability of patient care, is Section 232. This section would authorize states to develop their own methods and standards for payment of reasonable costs for inpatient hospital care under the Medicaid and Maternal and Child Health Programs.

Since the very inception of the Medicare and Medicaid programs in 1966, tremendous effort has been expended by the hospital field and by the Federal Government to provide for uniform cost findings, records, and billings. This effort has avoided expenditures which otherwise would have been required to develop cost finding systems to comply with different reimbursement formulas. Certainly, if Section 232 is enacted, it will eliminate the benefit of the substantial progress that has been made to simplify the accounting involved in Title XVIII and XIX. Further, it would nullify the potential for simplification and coordination of the administration of these Titles. It would be a backward step which would inevitably increase the cost of administration of these programs.

It is our understanding that this proposal was put forth by the states to reduce expenditures. Since Section 232 would prohibit reimbursement *in excess* of the Medicare formula, it can only be intended to allow states to pay hospitals *less* for services provided Medicaid patients than the Social Security Administration has determined to be fair and reasonable under the Medicare formula.

We are concerned that the Medicare formula does not even now require the Federal Government to pay a fair share of support for the community hospitals. Certainly, any proposal which would permit the states to pay even less than costs as determined under the Medicare formula would be completely inequitable and unfair to hospitals.

There can be only two likely results from the enactment of Section 232. Hospitals will either have to reduce the number of poor and near poor patients for whom they can provide services or the Federal Government will have to provide some form of subsidy to keep hospitals from bankruptcy. The number of private paying patients to whom hospitals must turn to recover their unreimbursed community service costs is extremely small. If this amendment is passed, the total amount of unrecovered costs will be increased and hospitals will be forced to "Robin Hood" these costs from a dwindling group of other patients, thus creating for them an intolerable burden.

Frankly, gentlemen, our field has great difficulty in comprehending the rationale by which the Federal Government would on the one hand, authorize the states to pay less than cost as determined under the Medicare formula for the care of Medicaid patients; and on the other hand, refuse under the Medicare program, to pay any share of the deficiency arising from such "less than cost" services.

RECOMMENDATION

We strongly urge that the committee delete Section 232 from the bill.

Mr. Chairman, hospitals are fully cognizant and understanding of the concern of the government in respect to the cost of hospital care and recognize the need for controlling these costs. A number of provisions in H.R. 1 are designed to accomplish this purpose and we are in general agreement with many of these.

We believe that a major improvement in the delivery and financing of health care is necessary in order to provide comprehensive care in the most economic and efficient manner possible. The American Hospital Association has invested

extensive resources in basic studies and in the development of guiding principles to accomplish this goal. We presented our recommendations in the matter to this committee in April of last year and to the House Ways and Means Committee last November in the course of hearings on the subject of National Health Insurance.

We are making every effort to bring about planning controls so as to assure that neither health facilities nor services can be developed or operated unless it can be demonstrated that they are needed by the community.

We are exerting efforts to bring about the development of rate review mechanisms or agencies at the state level which must sanction any changes in hospital rates. In essence this would require all hospitals to justify their rates.

Further, we strongly support experiments and demonstration projects that would involve reimbursement to hospitals on the basis of prospective rates. This would require individual hospitals to work within a prospectively approved budget in contrast to the present method of reimbursement which is largely on a retrospective basis.

Accomplishment of several of these goals will require Federal financial support for experiments and demonstrations and we are pleased to note H.R. 1 contains provisions authorizing such financial assistance.

UTILIZATION REVIEW

The Association favors strong utilization review programs and has expended great efforts in attempting to insure good utilization review in our hospitals. Today every hospital has some form of professional review of the utilization of its facilities and services. Our statistics show a gradual continuing decline in the average length of stay of hospital inpatients. We believe hospital utilization review committees have contributed substantially to this reduction.

H.R. 1, as passed by the House, would provide under Section 222 authorization for the Secretary of Health, Education, and Welfare to develop and carry out experiments and demonstration projects in areawide peer review, utilization review, and medical review mechanisms. We are in full agreement with this provision. It seems clear that in addition to good and effective review procedures within individual institutions there is evidence of the need for continuing overall review of such procedures by a body outside the individual health care institution. We believe that experiments should be undertaken with a variety of review mechanisms. It would also be important to include in such experiments care provided in nursing homes, physician's offices and ambulatory care facilities outside the hospital setting. These various experiments should be compared for their effectiveness in a study program conducted by the National Center for Health Services before any one model is accepted to cover the entire country.

In testifying before this committee last year on H.R. 17550, we expressed our real concern with the Professional Standards Review Organization amendment sponsored by Senator Bennett. The amendment called for the establishment of PSROs with primary control centered in local medical societies, to conduct ongoing reviews of the maintenance and regular examination of patients, practitioners, and provider profiles of care and services. We support the goal sought to be accomplished by Senator Bennett's amendment, however, we believe that it would be a great mistake to establish a program of such magnitude on a nationwide basis without carefully organized demonstrations or experiments to ascertain the results of such a program, the administrative problems and the effects on the delivery of quality medical care, as well as the cost involved.

Because of these concerns which we today reiterate to the committee, we are pleased that H.R. 1, as approved by the Ways and Means Committee and passed by the House of Representatives would in Section 222 specifically authorize the Secretary of Health, Education, and Welfare to develop and engage in experiments and demonstration projects for areawide peer review, utilization review, and medical review mechanisms.

RECOMMENDATION

We urge the committee's acceptance of Section 222 of H.R. 1 as passed by the House. If it is approved, you may be sure that the American Hospital Association and its member hospitals are ready to provide whatever assistance we can in the initiation and continuation of appropriate demonstrations and experiments.

MEDICARE COVERAGE FOR DISABLED BENEFICIARIES

Abundant statistical data is available to confirm the simple observation that the disabled require more medical care than those who are not disabled and that the cost of such care is extremely high. Low incomes are also characteristic of the disabled who cannot work regularly. Providing Medicare benefits to Social Security disability beneficiaries and to disabled qualified railroad retirement annuitants who have been entitled to disability benefits for at least two years would of course greatly help a large and deserving group.

Last year coverage of the disabled under Medicare before they reach the age of 65 was considered but not included in either the House or Senate versions of H.R. 17550, presumably because of the additional program costs that would be involved. We agree with the statement in the Report of the House Ways and Means Committee on H.R. 1 that because of cost and financing considerations it is "imperative to proceed on a conservative basis" in providing coverage for the disabled.

We are not opposed to extending Medicare benefits to the disabled. We would however point out that many disabled patients in health care facilities require extra amounts of nursing and ancillary services and providing such coverage

We recommend that if Medicare coverage is extended to the disabled under will be very costly.

RECOMMENDATION

65, the government should at the same time provide a realistic basis for financing the coverage in order to keep the trust fund on a sound basis.

OUT-OF-HOSPITAL DRUG BENEFITS

As requested by Senator Montoya, we are pleased to include in our testimony comments on his bill, S. 936 (amendment 464 to H.R. 1) which would establish a program of out-of-hospital drug benefits under Part A of Medicare.

For many of the elderly the purchase of drugs is one of the biggest items in their budget and it often constitutes a real hardship because of their limited income. As in the case of extending Medicare coverage to the disabled, there can be no doubt that an out-of-hospital drug program would help a very large group of beneficiaries. The cost to the government for providing such benefits will likewise be very substantial.

We are pleased to note that S. 936 (Amend. 464) embodies some suggestions made by our Association in previous testimony, including a requirement that the out-of-hospital drugs to be provided Medicare beneficiaries be listed by generic names and that the government establish a limited list of specific drugs to be covered—those that are most needed by aged patients and which constitute for them the greatest financial outlays. There are various sources that could provide guidance in the development of such a list.

Further, we believe that at least in the initial stages of such a program it will be necessary for the government to establish effective cost controls over the program. This could be done by fixing an annual dollar limitation on the purchase of the listed drugs for each beneficiary or by requiring a copayment for each purchase of drugs under the program, or it might be necessary to use both methods of cost control.

LIMITS ON MEDICAL PAYMENTS FOR SKILLED NURSING HOME AND INTERMEDIATE CARE

Section 225 of H.R. 1, would limit Federal financial participation in reimbursement for skilled nursing home and intermediate care per diem to 105 percent of prior levels of payment. Exceptions would be authorized to account for increases in the Federal minimum wage or other increases arising from Federal law.

This provision is completely arbitrary with no reasonable relation to the economics involved. While exception is granted for expenses resulting from direct Federal legislative mandates, no exception is authorized for other legitimate increases, not even from the indirect application of Federal programs such as the obvious reflection of increased minimum wages in charges by suppliers of equipment, etc. Certainly, if a ceiling is to be established it should recognize all legitimate increases in cost to the provider, such as the maintenance of wage differentials in health care facilities resulting from any increase in the minimum wage and as reflected in the increases in the cost of supplies and commodities.

There are continuing pressures from the public and the government for improvement of the quality of care in nursing homes and intermediate care facilities. There are also pressures for adding new services for patients in such facilities. Enactment of Section 25 would make it practically impossible for these institutions to increase patient services or improve the quality of care they are providing.

SUPPLEMENTAL MEDICAL INSURANCE

Section 203 of H.R. 1, would limit premium increase for Part B, supplemental insurance, to not more than the percentage by which the social security cash benefits have increased since the last Part B premium adjustment. Any excess cost would be paid out of general revenues. Section 204 would increase the Part B medical insurance deductible from \$50 to \$60; Section 205 would revise the co-insurance factor to begin with the 31st day; and Section 206 would provide for automatic enrollment for supplemental medical insurance.

We do not question the need or desirability of these changes in the Supplemental Medical Insurance Program as it is now structured. However, we continue to feel as we have expressed to the committee in the past, that the Part B program should be combined with Part A.

Combining Parts A and B would afford future beneficiaries the opportunity to prepay the cost of physician services in exactly the same manner as they presently prepay the cost of institutional health care services. It would certainly facilitate the understanding which aged persons have of the benefits to which they are entitled and would provide a good base for the development of comprehensive care including preventive care, multiphasic screening and other ambulatory health services while at the same time simplify and make less expensive the administration of the program.

We are pleased that the President in his State of the Union message proposes to eliminate the Part B Medicare premium which all who voluntarily enroll in the program must pay. This would make Part B benefits available to all Medicare beneficiaries without payment of a premium.

INCENTIVES FOR STATES TO UNDERTAKE REQUIRED INSTITUTIONAL CARE REVIEW ACTIVITIES AND TO EMPHASIZE COMPREHENSIVE HEALTH CARE UNDER MEDICAID

Section 207 of H.R. 1, provides, with some exceptions, for a one-third reduction in the Federal Medicaid matching share for total inpatient stays in a fiscal year which exceed: 60 days in a general or TB hospital; 60 days in a skilled nursing home; and 90 days in a mental hospital, with a lifetime limit of 365 days of care in a mental hospital. At the same time, provision is made for an increase of 25 percent in the Federal Medicaid matching share for amounts paid by states under contract with a health maintenance organization, a community health center, or similar facility providing comprehensive health care.

A somewhat similar provision was included in the House version of H.R. 17550 last year. The proposed reduction in Federal Medicaid matching was identical to that proposed here. However, the 25-percent increase in Federal Medicaid matching was proposed as an incentive for ambulatory care and was conditioned on payment being made by the state for hospital outpatient, clinic, and home health services rather than on payment of the 25 percent increase to states making payments to a health maintenance organization, a community health center or other similar facility providing comprehensive health care as now proposed.

In commenting on the proposed one-third reduction in Federal matching in H.R. 17550 last year, we pointed out that this reduction would result in a very substantial decrease in funds available for care of Medicaid patients and that it would be extremely doubtful that any such decrease in funds would be made up by the states. Thus, the end result would inevitably be a cut back in the care of the beneficiaries and any savings—estimated at \$235 million—would be at the price of rendering that much less care.

We agree, of course, that emphasis needs to be put on treating patients on an ambulatory basis and for this reason we felt that the provision in H.R. 17550, to pay a 25 percent bonus on Federal matching to states when payments were for outpatient, clinic and home health services was a good incentive to move in this direction. The current provision in H.R. 1, would, however, change the formula for the 25 percent increase to a requirement that payment by the state be made to a health maintenance organization or other type comprehensive health care facility.

We fully support the HMO concept as a means of providing a more comprehensive type of care. However, today and for the near future comparatively few people throughout the country have available to them the services of an HMO or other type of comprehensive health care organization. For this reason it would seem to us that the movement to comprehensive care for all the people of this country would be better advanced by providing the increased payment as an incentive payment not only to HMOs and other comprehensive care facilities, but also for all ambulatory type care—outpatient, clinic, and home health care, as originally proposed in H.R. 17550.

PROVIDER REIMBURSEMENT REVIEW BOARD

This committee in reporting out H.R. 17550 in the last Congress added a provision establishing a Provider Reimbursement Review Board which would be empowered to review claims on appeal by a provider from decisions of the intermediary on final settlements of their costs. The amount in controversy would have to be \$10,000 or more but could be cumulative as to a group of providers if the matter in controversy involved a common question of fact or interpretation of law or regulation.

H.R. 1, as it is before this committee contains a similar Provider Reimbursement Review Board provision. However, it has been limited to individual claims in the amount of \$10,000 or more and does not include coverage for claims involving a common issue as was originally authorized by this committee.

Since all providers of health care are bound by the cost formula prescribed by the government for payment for Medicare patients obviously many of the questions raised involving the law and regulations governing such payments will have a commonality of interest to the providers and cumulatively could represent very substantial amounts and have a serious financial impact on the operation of all hospitals serving Medicare patients. For this reason we urge the committee as a minimum to restore this right of review on a common issue as it was contained in H.R. 17550 of the last Congress.

Frankly, gentlemen, we do not think the provision, even then, will do complete justice to the hospital field. Under the provisions a provider would have a right to appeal to the Board a decision of the intermediary and the Board's decision on such appeal would be final unless reversed or modified by the Secretary adversely to the provider. If the Board finds adversely to the provider and its decision is affirmed by the Secretary, the provider is prohibited from pursuing the matter further and from having his "day in court".

We would like to see the provision broadened to allow providers to have any adverse decision involving a reasonable amount—cumulative to cover items of common interest to a number of hospitals—decided by a court of law, at least to the same extent as is currently authorized under the Social Security Law for its other beneficiaries.

RECOMMENDATION

We therefore recommend that Section 1815 of the Act be amended to include the following provision:

"Determinations by the Secretary under this Section shall be subject to administrative hearings to the same extent as is provided for in Section 205 (b) of the Social Security Act and in the case of a determination involving payment to a provider of \$1,000 or more or in the case of an expenditure, regardless of the amount which by agreement between the provider or his representative and the representatives of the Secretary, constitutes a principle of reimbursement common to all providers, to judicial review of the Secretary's final decision after such hearings as provided for in Section 205 (g) of such Act."

PHYSICAL THERAPY SERVICES UNDER MEDICARE

Providing Part B Medicare coverage for the services of physical therapists in independent practice when furnished in a practitioner's office or the patient's home would have the undesirable effect of splintering such services from the facility-based health team. It can be anticipated that approval of such a provision would lead to requests for similar Part B coverage for the services of other members of the health team, for example, psychologists, social workers, speech therapists, etc. Such fragmentation of health services would be extremely unwise.

Placing an annual dollar limitation on total payments for physical therapy services provided to a beneficiary in his home or a practitioner's office as a cost control mechanism and as an attempt to guard against abuse of the benefit would require a tremendous amount of complicated and expensive paper work and administrative procedures. Without doubt it would significantly increase the administrative cost of the program.

RECOMMENDATION

We recommend deletion of Section 251.

EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAM

Section 268 exempts Christian Science Sanatoriums from the requirements established for skilled nursing homes in regard to maintaining detailed medical records, having diagnostic and other service arrangements with general hospitals, and having a skilled nursing home administrator licensed by the state.

There are a great number of hospitals that are owned and operated by various religious denominations. Each of these are required to meet all the standards specified for participation in the Medicaid program. We see no reason whatever why a sanatorium operated by any church group should be exempted from the standards established by the law, yet be free to benefit from its provisions. All institutions participating in the program should meet the prescribed standards.

Similarly, we see no justification for the exemption of Christian Science sanatoriums from the provisions of Section 221 of the bill.

RECOMMENDATION

1. That paragraph (h) of Section 1122 as added by Section 221 of the bill be deleted.
2. That Section 268 of the bill be deleted.

STUDY OF CHIROPRACTIC

The Department of Health, Education, and Welfare has in the past conducted an extensive study of chiropractic, which resulted in enunciation of the position that chiropractic does not come within the healing arts. In view of such past studies and findings, we believe there is no need to spend the taxpayers' money for the study and report called for in section 273 of H.R. 1.

RECOMMENDATION

We know of no scientific basis for including the services of chiropractors under the Medicare program. We recommend deletion of Section 273 of H.R. 1 and further, that no provision to cover the services of chiropractors under Medicare be added to the bill.

SPELL OF ILLNESS

An area which we feel lends itself to greater simplification with consequent monetary savings is the area of deductibles required to be accounted for in almost every phase of care authorized under Medicare. We have recommended in the past and want to reiterate here today our strong belief that substitution of a reasonable coinsurance factor in lieu of deductibles would eliminate tremendous administrative problems, would benefit the hospital and the patient, and would result in substantial savings in the cost of the program.

As an example, when a patient enters the hospital he begins a "spell of illness" and determination must be made as to whether his hospital deductible has been previously paid. This necessitates contacts by the hospital with the intermediary and with the Social Security Administration and approximately one-half of the time the answer does not reach the hospital until after the patient has been discharged.

We believe that the law could be changed to provide beneficiaries with unlimited care—365 days a year—with no additional cost to the program, and in fact, with substantial administrative savings. This could be accomplished by initiating a co-payment on every admission, plus a small daily payment for each day of hospitalization. Admittedly, since this copayment would be on each admission, some beneficiaries would pay it more than once. However, we understand that the relative costs of such approach have been computed by employees of the Social Security Administration based on 1969 experience. For

that year for the same program costs each beneficiary could have been authorized needed inpatient care for a copayment of \$35 per admission, plus \$1 for each day of hospitalization. Not only would this promote better understanding by our older citizens of the Part A benefit, but it would eliminate very significant administrative problems, without increasing program costs and with savings in administrative expenses which easily will run into millions of dollars.

RECOMMENDATION

We recommend that the spell of illness provisions of existing law be revised to provide for 365 days a year of hospital care with a reasonable copayment for each admission and a reasonable per diem copayment throughout the length of any hospital stay, the amount of such payments to be reviewed annually by the Secretary of Health, Education, and Welfare.

We greatly appreciate the opportunity of presenting the views of the American Hospital Association to the committee. We will be glad to answer any questions or furnish any additional information which will be helpful to the committee in its deliberations.

Washington Hospital Center, the effect of cost-formulas which do not participate in all the financial costs and needs of the hospital

Total non-paying patients (bad debts) for 1971 at	
WHC: 4½ percent of \$40,000,000 (gross business) -----	\$1, 800, 000
<hr/>	
Medicare 23 percent of total business	
Medicaid 8 percent of total business	
31 percent of \$1,800,000 (bad debts) -----	558, 000
85 percent cost on charges: Amount which had to be re-	
covered by overcharging paying patients -----	474, 300
<hr/>	
City cases 2 percent of total business -----	800, 000
Charity cases ½ percent of total business -----	200, 000
<hr/>	
Total charges city and charity services -----	1, 000, 000
85 percent Cost on charges -----	850, 000
Reimbursement received* -----	280, 000
<hr/>	
To be recovered by overcharging paying patients -----	570, 000
<hr/>	
Growth and development not paid by :	
Medicare total business -----	9, 200, 000
Medicaid total business -----	3, 200, 000
City total business -----	800, 000
Charity total business -----	200, 000
<hr/>	
Total business without provision for growth and develop-	
ment -----	13, 400, 000
4 percent growth and development not included in these contracts	
which had to be recovered from paying patients by overcharging	
services -----	536, 000
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*The city reimburses \$38 per inpatient day and \$6 per outpatient visit under its medical charities program. These figures amount to about 35 percent of actual charges.

Summary of unrecovered financial needs

Unrecovered costs:	
Nonpaying patients (bad debts) -----	\$474, 300
Charity and sub-cost contracts -----	570, 000
<hr/>	
Total unrecovered costs -----	1, 044, 000
Unrecovered growth and development -----	536, 000
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Grand total of deficiencies in financial contracts* -----	1, 580, 000
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*This amounts to an average of approximately \$6.20 per adult patient day.

Senator TALMADGE (presiding). Our next witness will be Dr. F. J. Pepper, vice chairman, American Veterans Committee. You may proceed, Dr. Pepper.

STATEMENT OF F. J. PEPPER, M.D., VICE CHAIRMAN, AMERICAN VETERANS COMMITTEE

Dr. PEPPER. Thank you, Senator.

Mr. Chairman, I am F. J. Pepper, M.D., I am a practicing psychiatrist and a Vietnam war veteran and served as a battalion surgeon in Vietnam in 1966 and 1967. I am the national vice chairman of the American Veterans Committee, and it is on behalf of the American Veterans Committee that I am appearing here today.

We welcome the opportunity to present our views to the Senate Finance Committee. I want to say the views to be presented are a general statement of the principles that we feel should be embodied in any legislation passed rather than a technical analysis of specific legislative proposals.

The American Veterans Committee is an organization of veterans of World War I and II, and the Korean and Vietnam conflicts. Our motto is "Citizens first—veterans second." We are therefore deeply concerned about legislation that would affect the welfare of some 13 million Americans.

As a veterans organization we have a special concern about the military security of our Nation. The strength of our country, however, can only be as strong as the strength of its people. We are dismayed by the figures of the Department of Defense which show that in 1964 about 35 percent of those who appeared for induction failed to meet the military's physical mental and moral fitness standards.*

Over 55 percent of the beneficiaries of welfare benefits are children, our future generation. Poverty, which causes inadequate nutrition, health services and a dismal environment can only result in a generation of adults with serious physical and mental deficiencies.

As veterans we have been the beneficiaries of various programs under the GI bill because this country recognizes the special needs of the returning servicemen. We are grateful for the benefits we received but also recognize that we have an obligation to support action by our country to meet the needs of others so that they can live and rear their children at a decent level of existence.

At our convention in June 1971, the following resolution was passed:

AVC urges action in this session of Congress to create a new system of income maintenance which will meet the basic needs of all individuals and families who are unable to work, whose earnings are inadequate and for whom jobs are not available. Such legislation should be based on the following principles:

1. A unified and largely federally financed program of assistance to assure equitable and efficient treatment and administration.

2. Benefits should be available to everyone in need—those in low paying jobs as well as the unemployed, those without families as well as dependent children and their parents.

*Dialog on the Draft, American Veterans Committee, 1967, p. 20.

3. Assistance grants should provide all Americans with an income adequate to sustain them in a state of health and minimal decency. If fiscal consideration precludes such immediate grant levels, then provisions should be placed in the legislation for orderly steps at time intervals to reach standards of adequacy for health and decency as determined by the Bureau of Labor Statistics with flexibility of grant levels to meet realistic variations in costs of living.

4. Incentives and realistic aids should be employed to encourage those eligible for public assistance to move into job training and full employment. No recipient should be required to take a job at less than the minimum Federal wage to prevailing area wage, whichever is higher. Recipients should have the right to keep enough earned income to make working more attractive rather than relying solely on public assistance. Further, public service jobs should be provided where there is a shortage of private or other public service jobs.

5. A declaration of need should be accepted as prima facie evidence of eligibility. Spot checks can be used to determine accuracy of eligibility and payment, such as those used in the social security and income tax programs.

6. Rearing children should be recognized as important and meaningful employment. Mothers of school age children should not be forced to accept work or training against their will.

7. Adequate child care facilities are necessary if working mothers are to take advantage of work and training programs. Provisions should be made for national standards for child care services. Child care should be not merely custodial but should be designed to meet the educational, nutritional, and health needs of the children. Care should be provided for elementary schoolchildren after school. The poor should be trained and employed as child care center workers. No family should be required to pay a fee for child care unless it has income sufficient to meet its needs with minimal decency.

We submit that these principles should be embodied in any welfare legislation. The action of this committee and Congress on this legislation will set the tone of our country's concern and demonstrate the extent that it cares for those in need.

Thank you.

Senator TALMADGE. Thank you very much, Dr. Pepper. Any questions?

The next witness is Mr. Chester Shore, chairman, Committee on Federal Legislation, Health and Welfare Council of the National Capital Area.

Is Mr. Shore here?

STATEMENT OF CHESTER SHORE, CHAIRMAN, COMMITTEE ON FEDERAL LEGISLATION, HEALTH AND WELFARE COUNCIL OF THE NATIONAL CAPITAL AREA

Mr. SHORE. Yes, sir, I am. Thank you.

Senator TALMADGE. Proceed, sir.

Mr. SHORE. Mr. Chairman, my name is Chester Shore and I am appearing as chairman of the Committee on Federal Legislation of the Health and Welfare Council.

The Health and Welfare Council of the National Capital Area embodies the District of Columbia and surrounding counties in Maryland and Virginia. We are supported by the United Givers Fund, and we both allocate funds for UGF and we coordinate the support of the private sector in the health, welfare, and community services area.

There are 219 organizations which are affiliated with us, and which represent the wide spectrum of social services in this area.

Our delegates assembly and board of directors, we submit, represents a broad cross section of the community.

Now we are concerned about this legislation for a number of reasons, and we have been working on this legislation ever since President Nixon first gave his statement with regard to the matter of welfare, and we have been in contact with health and welfare councils throughout the area and have worked with them on this legislation, and by "throughout the area" I mean throughout the country.

We feel that this legislation is of vital significance to this country. It vitally affects our member agencies because they have found that permanent change can come only if people are able to live with the basic decent necessities of life and that any counseling or other services that our private agencies affiliated with us can do are minimal unless these basic necessities are met.

We also are concerned about this legislation for basic humanitarian purposes. As this committee is aware, 55 percent of the recipients are children, who are our future generation. It would be, it is, both shocking and disgraceful that these children, many of them, are forced to live under conditions so that their lives are blunted, they are ill-nourished, ill-clothed, and ill-sheltered.

As this committee is aware, 16 percent of the recipients are the aged. I was a delegate to the White House Conference on the Aging and I heard both President Nixon and Senators Fong and McGee discuss how important it is that those of the aged who have contributed to our country should have the opportunity to live the rest of their lives in decency, and we have had other witnesses here today who have, particularly Senator Eagleton, who has stressed the problems of the aged.

We are also concerned about this legislation because of the relationship of poverty to social problems. Poverty causes ill health and crime and slums, and it must be clear to everybody that unless we do make this attack on poverty our problems of ill health and crime and slums will merely increase, and the cost to the future taxpayer will be considerably more than the cost of welfare legislation that will provide minimum decency for people.

Lastly, this legislation will set the tone of the country, as the previous witness has testified. It would show to what extent our country really cares for people in need.

Now, we have submitted a very detailed statement of the principles that we feel should govern welfare legislation and I would just like to comment briefly on each of those principles.

We have pointed out in our statement that H.R. 1 does create three good constructive steps: The adoption of national standards of minimum benefits, the extension to a certain extent of Federal welfare

benefits to some of the working poor, and the expansion of opportunities for job training and employment.

However, we have stated in our statement that H.R. 1 on balance is a step backward, and that it would create a welfare system worse than the present one.

The first question that has to be considered by this committee is the question of benefits. We submit that \$2,400 as provided in H.R. 1 is grossly inadequate, that is, \$2,400 for a family of four. Nobody can seriously state that a family of four can live on \$2,400.

In our statement we have pointed out what are the figures for people living in the District of Columbia. We have pointed out that \$2,400, which amounts to \$200 per month, is \$117 per month for a family of four less than what the Department of Welfare has stated to be the standard of need.

We have further pointed out that in the District of Columbia our figures show that a minimum of \$5,700 approximately is needed for a family of four to sustain a low cost life style.

We submit that S. 2747, which has been introduced by Senator Harris, does set forth an adequate level and a reasonable timetable for meeting that level of need.

Second, is the question of existing State benefits. When President Nixon first made his speech with regard to welfare reform he made a promise that no person under the new Federal welfare reform, no person should be worse off than he is now. However, under H.R. 1 there are no matching funds with State supplementation. There is therefore no mandate to the States to supplement Federal payment, and no incentive on their part to do so.

The result will be that many millions of Americans will be worse off under H.R. 1 than they are at present.

The third question is the coverage. We submit that assistance should be provided equally to all in need. We see no justification for denying benefits to individuals or married couples without children. We also see no justification for penalizing families with more than eight members. The additional family members are children, and they should not be punished for existing.

The next point we wish to cover is the question of income disregard with regard to those who are working. Under H.R. 1, \$2 out of every \$3 would be lost. 2 out of every 3 welfare dollars would be lost. In other words, H.R. 1 is both unfair and provides a strong disincentive to work. Further, H.R. 1 does not permit the deduction of work-related expenses.

There has been a recent article by Alice Rivlin in the Post which discusses this whole question very thoroughly, and I would commend that article to this committee. It points out that it is sheer hypocrisy for a government to state that it is trying to get people off welfare and into work if at the same time they penalize them by taking most of the money they earn from work and give them no incentive to work.

We suggest in our statement that HEW should be the sole administrator, and that would provide a single unified system.

With regard to work in training programs, we have discussed that in our statement. There are two points we wish to bring to the committee. One, we feel that with regard to the mothers who have—

Senator TALMADGE. Mr. Shore, I am sorry your time has expired. We will be delighted to insert your full statement in the record at this point.

Mr. SHORE. May I make one last statement, sir?

Senator TALMADGE. Sure.

Mr. SHORE. I would just like to read the last two paragraphs of our statement, Mr. Chairman.

We recognize the fiscal difficulties that many States are in. We strongly believe that help for the States should not blind us to the need for more help for human beings. In H.R. 1, the States are held harmless, but many people are hurt.

We are concerned, of course, with the costs of developing an adequate public welfare system. But we observe every day the costs of an inadequate system, not only in the constantly rising economic costs of halfway help for families unable to break the welfare cycle, but also, painfully, in thousands of wasted lives. If the Nation must tax itself more to truly reform the welfare system, or if it must cut back substantially on other kinds of expenditures, then it must. We cannot afford a society in which so many exist without the means to support themselves in health and decency and without the prospect of any basic improvement in their lives.

Thank you, Mr. Chairman.

Senator TALMADGE. Thank you very much.

Any questions?

Senator FANNIN.

Senator FANNIN. Thank you, Mr. Chairman: just one. I am just wondering, you say that "we recognize the fiscal difficulties that the States face." Do you recognize the fiscal difficulties this Nation faces now in the future? We owe more than all the other nations in the world combined. We face a deficit this year of maybe \$40 billion or \$45 billion. If we carry through with the full implementation of what you recommend, we would probably have a deficit of \$50 billion to \$60 billion or more. The dollar would soon be worthless. How can we do what you are asking us to do under the circumstance that faces us.

Mr. SHORE. Well, the question, Senator, is one of priorities. It is a term that is used a lot and perhaps it has become a cliché, but I think it is a term that is applicable. The question is, What is the most important thing we must do? The most important thing we must do is take care of our children, our future generation. We cannot afford to have them live in poverty, we just can't.

Senator FANNIN. No one wants to live in poverty—I don't want to prolong this—we want to do the very best we can. But we have priorities. One of the priorities we have is to defend this Nation and defend all the people of this Nation.

Mr. SHORE. I was very much impressed with the previous speaker who pointed out that, in the final analysis, the money we might spend on weapons systems would be meaningless unless we have a strong people, and the security of a country—

Senator FANNIN. We won't have a strong people unless we are free.

Mr. SHORE. And we won't have a strong people unless we see the people grow up in minimum decency.

Senator FANNIN. We certainly want to do that, but we want to do it within the ability of our people to pay for it. We certainly can't continue going into debt and debt and debt.

Mr. SHORE. May I make one other point, sir, and I think this is very important. One of the reasons we have a large number of people on welfare is that in the past we have neglected our children. Now I have a niece and nephew and they get a decent education, they are not hungry, nothing is going to happen to them. I am positive that when they grow up, the possibilities of their being unable to get a job or requiring assistance is nil.

On the other hand, I see in my office, I am an attorney, I see people who are on welfare, and I know people who are on welfare, and I see what is happening to their children, and I see that they, if they go hungry to school; then education, they can't get a decent education, and, if they grow up in this poverty, then the chances are they might possibly be the future people on welfare.

Senator FANNIN. You are talking about different matters altogether. We want to give the best educational program we can to every city and town in this Nation so that isn't what I am talking about.

Mr. SHORE. But if a child goes hungry a child cannot learn.

Senator FANNIN. We are not talking about a child going hungry, we are not talking about children going hungry, we are talking about being able to pay for a program.

Mr. SHORE. I would submit as a taxpayer, and I would submit also that our organization represents a very broad section of the community, we are willing to make this payment. We feel in the long run it is not only humanitarian but it is in the best interests of our country.

Senator TALMADGE. Any further questions?

Thank you very much, Mr. Shore.

(The prepared statement and attachment of Mr. Shore follow. Hearing continues on p. 2299.)

PREPARED STATEMENT OF CHESTER SHORE, CHAIRMAN, COMMITTEE ON FEDERAL LEGISLATION, HEALTH AND WELFARE COUNCIL OF THE NATIONAL CAPITAL AREA, TITLE IV OF H.R. 1

The Health and Welfare Council is the central organization for developing and coordinating the support of the voluntary sector for health, welfare and related community services in the greater metropolitan area of Washington. It is a non-profit organization financed chiefly by the United Givers Fund and is responsible for the allocation of UGF funds to eligible private voluntary agencies. The Council is a citizen-led organization representative of all segments of the metropolitan area.

The 219 organizations affiliated with the Council represent the entire range of voluntary social services. Some agencies operate under contract with public agencies; nearly all of them work in some way with people whose lives are influenced by Federal welfare assistance. We offer these comments on the proposed Family Assistance Plan and Opportunities for Families program in light of our experience and our concern with the problems of low-income people.

Over time the HWC agencies have learned the obvious: the very first thing poor people need is money. We believe strongly in the value of social services. Many of our affiliated agencies are providers of these services. But we know equally well that the counselling and other assistance that agencies offer cannot really change things for families that do not have enough cash to live on. Until these families can buy food, clothing and shelter and have some cash to cope with emergency needs, welfare agencies can do next to nothing to help them in any permanent sense and there is little most can do next to help themselves.

We believe therefore that an adequate welfare reform bill would clearly state a federal policy to insure that all Americans can achieve an income adequate to

meet their basic needs. It should set goals of federal benefit levels calculated to meet these needs and it should fix a timetable for reaching these goals. Federal benefits should be automatically adjusted for increases in the cost of living. They should also reflect regional cost-of-living variations, and differences in rural and urban areas.

S. 2747, the Family Income Maintenance and Work Incentive Act, introduced in the Senate by Senator Fred Harris establishes what we think are adequate levels and a reasonable timetable for reaching these levels. Under that bill minimum benefits would start at the poverty level (currently \$3,960) and increase in steps to the "cost of family consumption" component of the Bureau of Labor Statistics national lower living standard by 1976. Federal assumption of all costs would be phased in concurrently.

We have examined H.R. 1 as it was passed by the House. We find in Title IV of the bill three constructive, if inadequate, steps toward the kind of welfare system that will meet the needs of our community and the nation:

The bill adopts the principle of national standards of minimum benefits, and establishes a single national standard of eligibility for benefits.

The bill would extend federal welfare benefits to some of the working poor, who are excluded from the present system, and thus would come closer to providing help to all who live in poverty.

Finally, the bill would expand opportunities for job training and employment. It recognizes that supporting services are necessary in order to make training and employment possible, and, in particular, it provides an expanded child care program for families of participants in work and training programs. As we point out below, however, these expanded programs still fall far short of needs.

Last year, when we examined the original Administration proposal for a family assistance plan, our analysis was that, despite some obvious weaknesses in the plan, if the plan were adopted as proposed, we would have had on the whole a better welfare system. Now we believe that the extensive changes in the original proposal, introduced in this Congress as Title IV of H.R. 1, would take us backward rather than forward, creating a welfare system worse than the present one and overwhelming the three improvements.

We comment in more detail on aspects of Title IV of greatest concern to the Health and Welfare Council and outline the principal ways in which we think the bill must be improved in order to meet the basic needs of the poor:

1. The basic minimum payment under the Family Assistance Plan, now proposed to \$2,400 per year for a family of four, should be raised to a level commensurate with need.

We do not think that anyone seriously suggests that \$2,400 per year is enough to sustain a family in a state of health and minimal decency. H.R. 1 would eliminate presently existing food stamp benefits. Even when state supplements are considered, benefit levels in most states would not nearly meet actual needs. In the District of Columbia, for example, where AFDC payments are slightly higher than the national average, total benefits for a family of four with no other income would be no higher than about \$200 per month. This level of \$200 is \$117 per month less than our Welfare Department's standard of need, and at least \$247 per month less than the minimum that experience indicates is necessary in this city to sustain life at a standard of minimal decency.

Research conducted in January 1971 by the Councils Committee on Federal Legislation revealed that a family of four in the Washington metropolitan area at that time needed a minimum income of some \$5,768 to sustain a low-cost lifestyle corresponding to Bureau of Labor Statistics budget components. Inflation has no doubt pushed that figure up by now. Items comprising the total included:

Food: \$1,920 (based on USDA low-cost food plan).

Housing: \$1,724 (including household operation).

Transportation: \$441.

Clothing and personal care: \$833.

Medical care: \$480.

Other family consumption: \$370 (reading, education, recreation).

If free school lunches and medical care are provided, the family's annual cash needs are reduced to \$5,125. On the other hand, the \$5,767 figure was based on the assumption that no member of the family was employed. If the father was working, cash needs would rise to \$7,598, a figure that includes work-related expenses and income and social security taxes.

2. The states should not be permitted to cut back existing benefits now paid to needy families.

A state should be required to maintain its present benefit level if it is higher than the federal minimum, and federal matching funds should be authorized to cover costs of state supplementation, until the adequate federal benefit level is reached. The dire trend of welfare cutbacks owing to the fiscal plight of the states must be reversed, not encouraged.

It is significant that H.R. 1, unlike current law and unlike last year's bill, provides no federal matching to pay part of a state's costs of supplementing welfare benefits. Instead, the bill holds the states harmless against increased welfare costs only if they do not raise benefit levels above those of January 1971. It eliminates the provision of present law for the federal government to pay half the costs of cost-of-living increases provided by a state. The states, in short, are severely discouraged from increasing present benefits, however inadequate they may be. And they have a stronger financial incentive to cut benefits. Under present law, a cut of one dollar in benefits means a reduction of 50 cents in federal matching funds. Under H.R. 1, if the states cut benefits, they lost not a penny of federal assistance.

S. 2747 requires benefits for all recipients, including those newly eligible, to be no less than January 1, 1971 level, plus bonus value of food stamps as of same date. All recipients, present and future, are covered. It requires states to reimburse the federal government for the amount by which maintenance of the January 1971 level exceeds the federal minimum. The federal government must administer all supplemental payments. S. 2747 also assures that state costs will not exceed fiscal 1971 welfare costs.

One of the premises on which the Administration's original welfare reform proposal was based was that no individual should be worse off under the reformed program than under the existing program. This principle was stated in the President's message two years ago. It should not be forgotten now.

3. Assistance should be provided equally to all in need.

We know of no justification for denying benefits to individuals or married couples without children. We believe that minimum subsistence benefits should be available to everyone in need—those in low-paying jobs as well as the unemployed, those without families as well as dependent children and their parents. Families with more than eight members should not be penalized by a \$3600 ceiling on benefits. The additional family members are children. They should not be punished for existing. The Harris bill disregards categories—i.e., working poor, blind, handicapped—and bases benefits solely on need.

4. A larger 'income disregard' is needed.

H.R. 1, like present law, provides that after a welfare family earns a certain amount of income (\$30 per month under present law, \$60 per month under H.R. 1), it must give up two dollars it earns. It is subject, in effect, to a 66⅔ percent tax on earnings. It is unfair to tax the very poorest as millionaires. It is also potentially a strong disincentive to work. The 50 percent tax rate of last years' bill was more fair.

H.R. 1 would change present law by requiring recipients to compute earned income without deducting many of the costs of working—such as transportation, lunch, union dues, uniforms, tools, and income and social security taxes. This is a step backward and another disincentive to work. The Harris Bill provides an incentive by allowing a family to disregard the value of all expenses reasonably attributable to the earning of income, including child care if it is necessary to enable a recipient to engage in work or training.

5. The bill should provide a single, simple, unified system of administration.

We favor the Department of Health, Education and Welfare as the sole administrator of the federal welfare program. We fear that responsibilities shared by HEW and the Department of Labor will result in greater expense and red tape for recipients, and a greater likelihood of administrative error and delays. For this reason we prefer the retention of the present administrative responsibilities in HEW as provided in the Harris Bill.

6. Participation in work and training programs should not be compelled. Rather, the bill should provide standards to ensure that programs offer real incentives and opportunities for productive work and training.

People receiving welfare are generally no different in their attitudes toward employment than other people. This is confirmed by an increasing number of studies, including the OEO-funded income maintenance project in New Jersey. It is confirmed by the experience of the workers in local agencies. Most people want to work and support themselves.

For this reason we think the bill's requirement that an individual accept employment or training is unnecessary. Particularly reprehensible—because it punishes children for acts of their parents beyond their control—is the threat of an \$800 reduction in the family benefit if any family member deemed “employable” does not accept whatever work or training is offered.

We understand and share the concern of spokesmen of the poor who say that such provisions will be used to coerce the poor into dead-end jobs at substandard wages. We fear that the prospect of coercion, no matter how infrequently coercion is actually applied, will so alienate people as to defeat entirely the objectives of the work and training programs.

We also know that the massive problem of underemployment in the District of Columbia, and no doubt elsewhere, arises primarily from the simple fact that there are not enough decent jobs, jobs that pay enough to support a family, available for those that want them.

Finally on the question of compelled work and training, if the past decade's experience with work and training programs has taught us anything, it is that the simple loss of a paycheck does not prevent enrollees from dropping out of programs in large numbers. We know by now that for a work and training program to be successful, it must offer positive incentives and must take positive steps to remove the obstacles that now bar many poor people from employment.

We suggest therefore that the following standards for work and training programs be added to the bill, whether or not participation in these programs is made mandatory.

All training should be for specific jobs. The experience in this community and, we think, in the nation at large is that this is by far the best way to insure that a training program will actually lead to employment. Where possible, the “hire first” principle, applied in the JOBS program and others, should be applied: a trainee should be first hired, then trained on the job. In any event, training of an individual should not begin until an employer has firmly indicated his intention to hire him when trained. In this time of high unemployment, it is clear that jobs are not available for all people who must register for training. We do not believe that people who enter training in good faith should bear the risk that there will be no jobs for them when their training is completed.

In appropriate cases, college education should qualify as “training” under the program. Recipients attending college should not be disqualified from benefits solely on the ground that they are receiving post-high school education. If we are sincere about breaking the poverty cycle in which a fifth of our population finds itself, we must encourage welfare recipients to obtain every kind of training for which they are qualified, not just training that prepares them for semi-skilled and unskilled labor.

In light of worsened economic conditions over the past year, the job training provisions of H.R. 1, and the 200,000 public service jobs authorized in the bill, are grossly inadequate compared with the need. It is unrealistic to require, as H.R. 1 would do, that after three years the states must assume the costs of public service jobs. After a few years, the jobs would simply cease to exist.

Since available training slots in the foreseeable future will be far fewer than the number of people available for training, the Congress should fix priorities for entry into training programs. Even if, as we hope will not happen, some people are ultimately required to accept work or training against their will, the first to enter these programs should be people who choose to do so. The present WIN program in the District of Columbia has been filled from its inception entirely with persons enrolled voluntarily.

Rearing children should be recognized as important and meaningful employment. In no event should mothers of school age or pre-school children be forced to accept work or training against their will. Our local agencies have for some time been concerned with the plight of the “latch-key child,” the child with no supervision after school and during school holidays. A study by the Arlington Health and Welfare Council, a member of HWC, has shown that it is these children who are most likely to show behavior problems at school and at home, the most likely to become involved with law enforcement authorities. Many mothers of school age children want to work, and some can make proper arrangements for the care of their children in their absence. If, however, all welfare mothers are made to work, the deterioration of the family and the damage to the children that can result would overshadow any conceivable benefits of their employment.

If employment is to be compulsory, strict standards of what constitutes suitable employment are necessary. These should be federally administered and enforced uniformly for private as well as public sector jobs. The bill should provide that no one shall be compelled to take a job that does not pay the federal minimum wage. Any job under the program must offer the opportunity for advancement based on ability. We endorse the guidelines proposed in the Harris Bill which direct the Secretary in determining suitability of a job or training program.

The bill would direct the Secretary of Labor to choose in each locality the one or more organizations best qualified to run training and employment programs. He should be able to contract with state, federal and local agencies, community action agencies and voluntary agencies. Very often—and we have seen this happen in our area—local, citizen-led organizations are better able than a state or federal agency to reach the people who need jobs and bring them into work and training programs.

8. The bill recognizes that adequate child care facilities are necessary if working mothers are to take advantage of work and training programs, but it does not take realistic steps toward providing this care.

Experience with the WIN program in this city, and studies that have been made elsewhere, indicate that a major obstacle that keeps welfare mothers who want to work from working is lack of adequate day care for their school age and pre-school children. The voluntary agencies are deeply involved in on-going child care programs. We believe that properly run child care programs are invaluable educational experiences for the children themselves. And we also know that if any substantial numbers of welfare mothers are to work, there must be day care for their children.

The need for child care facilities and for trained personnel to run them is great. The Social Service Administration of the Department of Human Resources of the District of Columbia has estimated that there are 25,000 children under age 5 in low-income families who have working mothers. An additional 10,000 to 15,000 children need after-school care. Yet the number of places for disadvantaged children now available in day care centers in the District is less than 4,000. This is the situation in a community that has been a leader in providing child care facilities. The need in other communities must be as great or greater.

We believe these needs can best be met by enacting a comprehensive child development law resembling the measure passed by Congress last session but vetoed. Such legislation would ensure quality care with parental involvement and local control. We do not consider provisions for child care offered in H.R. 1 to measure up to adequate standards for the emotional, nutritional and intellectual well-being of children.

With child development experts estimating the cost of quality care at \$2000-2300 a year per child, the proposed authorization of H.R. 1 is plainly inadequate. We do not think low-income parents should be required to bear this expense alone. Their child care costs should be underwritten by the federal government.

9. Administration and procedures should be less harsh, more flexible.

In this very important area, H.R. 1 would take a number of very serious regressive steps. These include:

An attempted overruling of the Supreme Court decision invalidating the one year residency requirements for eligibility for Public Assistance.

The bill also apparently attempts to set aside a recent Supreme Court decision holding that a recipient's benefits may not be cut off while proceedings to determine eligibility are pending.

Under present law, eligibility for assistance is based on present needs. Under H.R. 1, income in the previous three quarters is taken into account. A family whose head dies or loses a job could be ineligible for assistance for six to nine months.

While recipients of adult categorical assistance may qualify simply by filling out a form, family recipients must be put through a long and complicated investigation of eligibility before they can receive assistance. The declaration method specified in the Harris Bill has proved effective in the AFDC program and should be continued.

10. The social services appropriation should remain open-ended.

The presently open-ended authorization for social services appropriations would be closed under H.R. 1, except for 75 percent federal matching for child care and family planning.

Local agencies affiliated with our Council have been involved in providing social services to welfare recipients. We know these services to be essential in many cases to helping recipients leave the welfare rolls. An arbitrary limitation on funds for these purposes could well cripple ongoing efforts to help welfare recipients become self-sufficient.

Conclusion

Welfare reform is not a subject about which only the needy or only certain public officials are concerned. The voluntary agencies represented by the Health and Welfare Council, and the very many citizen volunteers who support these agencies, are also vitally concerned. We recognize that voluntary agencies can make a full contribution to the solution of the welfare problems that face us only if there are adequate public programs on which to build.

We recognize the fiscal difficulties that many states are in. We strongly believe that help for the states should not blind us to the need for more help for human beings. In H.R. 1, the states are held harmless, but many people are hurt.

We are concerned, of course, with the costs of developing an adequate public welfare system. But we observe every day the costs of an inadequate system, not only in the constantly rising economic costs of half-way help for families unable to break the welfare cycle, but also, painfully, in thousands of wasted lives. If the nation must tax itself more to truly reform the welfare system, or if it must cut back substantially on other kinds of expenditures, then it must. We cannot afford a society in which so many exist without the means to support themselves in health and decency and without the prospect of any basic improvement in their lives.

Respectfully submitted,

CHESTER SHORE,
Chairman, HWC Committee on Federal Legislation.

IMPROVEMENTS IN THE FAMILY ASSISTANCE PLAN CONSIDERED ESSENTIAL BY THE HEALTH AND WELFARE COUNCIL OF THE NATIONAL CAPITAL AREA, NOVEMBER 1971

1. The basic minimum payment under the Family Assistance Plan, now proposed at \$2400 per year for a family of four, should be raised to a level commensurate with need, and a fixed timetable for meeting these goals should be set. The goals should be adjusted for cost of living increases and for differences in living costs in different areas. At current price levels and in our area, we estimate the minimum that it costs a family of four to meet its needs is \$5,000 to \$5,500.

2. Existing benefits now paid to needy families should not be cut back. States should be required to supplement the federal benefit where present payments are higher, until a level of adequacy is reached.

3. Assistance should be provided equally to all in need—including individuals, couples without children, and "working poor."

4. A larger "income disregard" is needed. The 50 per cent tax rate of last year's bill was more fair than the 66⅔ per cent tax in H.R. 1. In addition, all work-related expenses should be tax-deductible.

5. The bill should provide a single, unified system of federal administration.

6. Participation in work and training programs should not be compelled. Rather, the bill should provide real incentives and opportunities for productive work and training.

All training should be for specific jobs.

In no event should mothers of pre-school or school age children be forced to accept work or training.

Suitable employment standards are necessary. Including a provision that no one shall be compelled to take a job that does not pay the federal minimum wage.

7. Adequate child care must be provided so that mothers who choose to, can work. Higher funding authorization and high standards must be included to ensure adequate adult-child ratios and nutritional, medical and intellectual components.

8. Punitive administrative procedures involving eligibility, application for benefits, and fair hearings should be modified.

9. The social services appropriation should remain open-ended, as under current law.

The Committee on Federal Legislation of the Health and Welfare Council considers S. 2747, The Family Income and Work Incentive Act of 1971, introduced by Sen. Fred Harris, to be the bill most adequately meeting these requirements.

Senator TALMADGE. The next witness is Mr. William H. Shaker, Delta Associates International.

Mr. Shaker, are you here, sir?

**STATEMENT OF WILLIAM H. SHAKER, DELTA ASSOCIATES
INTERNATIONAL**

Mr. SHAKER. Yes, sir.

Senator TALMADGE. Proceed, sir.

Mr. SHAKER. I appreciate the opportunity to testify today and it is certainly a pleasure to be here. In studying the previous testimony presented to this committee it is clear that you are asking the right questions and I am convinced that you are committed to finding a pragmatic solution to what has come to be known as the welfare mess.

In wrestling with this problem, I wonder if you ever feel like you can't win no matter what you do.

This chart shows the projected cost to 1977 of H.R. 1, along with several amendments that have been proposed. Now I have difficulty relating to a hundred billion dollars and I have therefore drawn as a reference the total after tax profits of all U.S. corporations combined. That is the blue line on the chart. I have studied this bill in the light of likely future changes, and their costs, both economic and social, and I am addressing some of the points I think that Senator Fannin just raised.

Now, I would like to show the impact of H.R. 1 and various proposed amendments on jobs. You are not going to be able to read this chart and the next series of charts but that is okay because you will be able to get the concepts that I am trying to get across.

Shown down the left of the chart are the States in alphabetical order. Across the top of the chart are jobs that would be affected by H.R. 1 and the various proposed amendments in H.R. 1.

I will analyze four cases. Case 1 is H.R. 1 as it is presently written. Case 2 is setting the guaranteed income at the \$4,116 poverty level. Case 3 is the \$4,800 guaranteed income floor that is proposed in Senator Javits' amendment and as case 4 I will show the impact on jobs of the demand of the National Welfare Rights Organization of \$6,500 a year.

Blocks representing jobs that pay less than a specified guaranteed income are going to be shown on the charts as red.

If jobs in the apparel industry, for example, in the State of Alabama paid less than a particular guaranteed income, the first square on the top left corner of the chart would be shown in red.

Here you see jobs that pay less than the H.R. 1 guarantee of \$2,400 plus State supplement. Quite a few jobs are already affected in the services sector of the economy.

Here you see jobs that pay less than the \$4,116 poverty level. The first column on the left represents the apparel industry which is essentially wiped out at this level. I say it is essentially wiped out because of world competition and world markets.

Senator HANSEN. If I could interrupt at a moment, let me be certain that I understand what you are saying.

Mr. SHAKER. Yes, sir.

Senator HANSEN. Do I gather that the red-shaded areas on the extreme left-hand side of your chart represent jobs that presently would pay less than the benefits that would be provided for people according to the terms of H.R. 1?

Mr. SHAKER. No, this chart shows the effect of moving the floor up to the \$4,116 poverty level.

Senator HANSEN. I see.

Mr. SHAKER. Thank you, because these things have been proposed several times in your hearings.

I want to point out the apparel industry exported goods last year totaling in excess of \$200 million. The effect of this legislation on our balance of payments would be disastrous.

Now, this is moving up to the proposed amendment of Senator Javits. You see an increasing number of jobs both in the manufacturing sector and in the services and trade sectors affected.

Now there have been those who have said yes, but people are going to work anyway, they get bored or something like that. Well, this may be but I think this argument is difficult to accept. You take a cook in California who under this condition would make more on welfare than he would collecting his paycheck. You can't tell me that he is going to continue to sweat in a kitchen when he can go sit on the beach and collect the same amount of money on welfare.

Most of these jobs are still going to have to be done so what will be the effect. The effect will be rampant inflation throughout the land because the paycheck will be competing with the welfare check. Over three-quarters of a million jobs in New York State, for example, pay less than the Javits guaranteed income. Eighty-five percent of the manufacturing sector of North Carolina pays less than this amount of money.

Finally we take a look at the impact on jobs of the National Welfare Rights Organization demand. NWRO demands might be dismissed as so much talk if it were not for the ever-widening circle of support they are getting. This committee has heard testimony in support of NWRO demands from such organizations as the National Council of Catholic, Jewish, and Negro Women, Church Women United, and the women's division of the United Methodist Church.

H.R. 1 would begin an inflationary spiral that this country has never known before.

Just as we can learn from our own experience we can learn from others. Our written statement reviews the experience of Uruguay with similar legislation.

This chart shows the relative change in the standards of living, that is in real per capita income of Uruguay. This is between 1950 and 1969. In the middle 1950's Uruguay's living standard was comparable to much of Europe and double that of Japan. At that time Uruguay launched an all-out campaign to eradicate poverty with social programs similar to the administration's family assistance program.

How much inflation? Well between 1963 and 1968, inflation in all of Latin America averaged a hundred percent, awfully high. Would you believe that it was 1600 percent in Uruguay during that same period? Disaster could be wrought on the economy by merely redistributing less than one-half of 1 percent of the gross national product. This legislation would block a way out of the welfare mess forever.

How would the administration's family assistance plan affect the Nation? Senator Ribicoff of this committee said:

I think the country must realize that we are basically changing the social philosophy of the United States once we put this into effect. None of us can anticipate the consequences, but we are definitely starting this nation into a new social program * * * you put 25 million people into a new social program and you are changing society—we do not know the impact that it will have on the people benefited and the people outside the program, their concepts, their reactions and what it will lead to * * *

This study suggests what some of these consequences are likely to be and gives a foretaste of future changes and what the future cost of the welfare plan would be to the Federal Government and to society.

I would like to review a little history. Shown on the top chart is the maximum effective income tax rate starting in 1913. Now there is debate in Ways and Means as to the advisability of limiting the maximum tax rate to 10 percent. This was dismissed as unnecessary because it was obvious that the tax rate would never reach 10 percent. The middle chart shows the spending record for social security programs in billions of dollars. Social security benefits have been increased continuously, especially during election years, and last of all you see the historical costs of public aid along with the projected costs of H.R. 1, and the various proposed amendments, as you saw on one of the earlier charts. I think the parallels that I am trying to draw here are obvious; 1977 costs may not be the top line of \$115 billion. But I think it is doubtful it will be the HEW estimate which is shown at the bottom.

Let's look ahead 5 years. Testimony of previous witnesses is used in painting the picture of the future. The likely immediate changes would include elimination of work requirement, a substantial increase in the income floor, and inclusion of single individuals and childless couples. Heard, for example, is the spokesman for the Friends Committee on National Legislation agreeing that able-bodied adults that choose not to work, that do not offer themselves for hire at all, should be given an adequate income as a matter of right.

Echoing these sentiments was testimony given on behalf of organizations such as the National Council of Catholic Women, Jewish Women, Church Women United, and the National Consumers League. Their position, "In our judgment, it is neither necessary or desirable * * *"

Senator TALMADGE. Mr. Shaker, I am sorry your time has expired. We will insert your full statement in the record.

Are there any questions?

Senator FANNIN. Mr. Chairman, I just want to commend you, Mr. Shaker, for bringing to our attention the seriousness of this matter, and for furnishing that much information, this detailed information, which will be studied, I assure you, very thoroughly.

It is shocking to see what is projected, and I think it is a very valuable contribution you render to our committee.

Mr. SHAKER. Thank you, sir. I just want to add in our written statement we do outline a proposed alternative to this bill, and it is what we are calling guaranteed job opportunity. This is outlined in some detail in our written statement.

Senator FANNIN. Thank you.

Mr. SHAKER. I hate to, I don't like to, criticize something unless I have something to offer as an alternative.

Senator FANNIN. Thank you.

Senator TALMADGE. Mr. Shaker, I too want to compliment you on your testimony. I have been tremendously impressed by your testimony, so much so that I plan to take your full statement home and read it in its entirety and I hope other members of this committee and the news media will do likewise.

Senator HANSEN.

Senator HANSEN. I would just like to ask Mr. Shaker, the charts you have explained on the screen are contained in the statement?

Mr. SHAKER. Yes, sir; they are.

Senator HANSEN. So they will be available to the committee.

Mr. SHAKER. They will be available.

Senator HANSEN. Let me also compliment you for exploring in depth and pointing out what you think may very well be the results of some of the proposals that are now before this committee. I think you have done very important work. You have provided a vital service to us in order that we may better assess what could be the results, or the impact, of some of the proposals that have been made.

It seems to me, Mr. Chairman, to underscore the good wisdom in the observation you made yesterday, to which I subscribe wholeheartedly and without reservation, when you said that you thought that it was fine to undertake a pilot project but you see no reason at all to include with that authorization, and the appropriation necessary to undertake such a test effort, the implementation of a bill at a time certain.

I think that if the project proves its merit Congress will certainly be persuaded by its success.

Senator TALMADGE. Will the Senator yield? It is like buying a house before you inspect it. You purchase it and then have the right to inspect it afterwards.

Senator HANSEN. Precisely. Thank you.

Mr. SHAKER. One thing about the testing, if you are going to test you should design the testing program so it will be flexible enough so people like Governor Reagan can try some of his experiments also. I think if you put too many constraints on it you won't ever find anything out.

This chart is just in our statement, too. It shows the results of a program in Puerto Rico where they also set out to eliminate poverty; but their approach was different. It involved private enterprise. This chart is also in the written statement. It compares Puerto Rico's progress with Uruguay.

Senator HANSEN. Thank you.

Senator TALMADGE. Thank you very much, Mr. Shaker.

(The prepared statement and attachments of Mr. Shaker follow. Hearing continues on p. 2335.)

PREPARED STATEMENT OF WILLIAM H. SHAKER, DELTA ASSOCIATES INTERNATIONAL
AN ANALYSIS OF THE ADMINISTRATION'S FAMILY ASSISTANCE PLAN WITH
RECOMMENDATION FOR EFFECTIVE WELFARE REFORM

A Research Report to the Senate of the United States :

Summary of Key Points

My name is William H. Shaker.

I appreciate the opportunity to testify and it is a pleasure to be here. In studying previous testimony presented to this committee it has become clearly evident that you are asking the right questions. I am convinced that you are com-

mitted to finding a pragmatic solution to the "welfare mess," and I hope that my testimony and our previously submitted written material will be of some help. In wrestling with this problem do you ever feel like you can't win—no matter what you do?

This chart (Exhibit 1, page 5) shows the projected cost to 1977 of H.R. 1, along with several amendments that have been proposed. I have difficulty relating to \$100 billion and have therefore drawn, as a reference, the total after-tax profits of all United States corporations.

I would now like to review a little history because we can learn from it (Exhibit 2, page 6). Shown on the top chart is the maximum effective income tax rate, starting in 1913. There was debate in Ways and Means as to the advisability of limiting the maximum tax rate to 10%. This was dismissed as unnecessary because it was obvious that the tax rate would never reach 10%. The middle chart shows the spending record for social security programs. Social Security benefits have been increased continuously, especially during election years. And last of all you see the historical cost of public aid, along with projected costs of H.R. 1 and the various proposed amendments.

Now, I would like to show the impact of H.R. 1 and various proposed amendments on jobs. You're not going to be able to read this chart—the details of it—but that's okay because you will be able to get the concept. Shown down the left of the chart (Exhibit 4, page 16) are all of the states. Across the top of the chart are jobs that would be affected by H.R. 1 and proposed amendments to H.R. 1. I will analyze four cases: H.R. 1 (Exhibit 4, page 16); setting the guaranteed income at the \$4,116 poverty level (Exhibit 5, page 17); the \$4,800 guaranteed income floor that is proposed in Senator Javits' amendment (Exhibit 6, page 18); and then lastly, I will show the impact on jobs of the demand of the National Welfare Rights Organization of \$6,500/year (Exhibit 7, page 19). Blocks representing jobs that pay less than a specified guaranteed income will be shaded in. If jobs in the apparel industry in the state of Alabama paid less than a particular guaranteed income the first square in the top left corner of the chart would be shaded in. Here (Exhibit 4), you see jobs that pay less than the H.R. 1 guarantee of \$2,400 (plus state supplements).

Quite a few jobs are already affected in the services sector of the economy. Here (Exhibit 5), you see the number of jobs that would be affected at the \$4116 poverty level. Moving upward to the proposed amendment of Senator Javits (Exhibit 6), you see an increasing number of jobs, both in the manufacturing sector and in the services and trade sectors, affected. There have been those who have said, "yes, but people are going to work anyway. Maybe it's because they get bored"—well, this may be—but this argument is difficult to accept. Take a cook in California—is he going to continue to work in a sweaty kitchen when he can go and sit on the beach and collect the same amount of money on welfare? Most of these jobs are still going to have to be done. So, what will be the effect? The effect will be rapid inflation throughout the land because the paycheck will be competing with the welfare check. Finally, we take a look at the impact on jobs of the \$6500. National Welfare Rights Organization demand. N.W.R.O. demands might be dismissed as so much silly talk if it were not for the ever-widening circle of support that they are getting. This committee has heard testimony in support of N.W.R.O. demands from such organizations as National Councils of Catholic, Jewish and Negro Women; Church Women United; and the Women's Division of the United Methodist Church. These "income as a matter of right" plans will affect a larger section of the economy than that represented by the lady that Senator Long has referred to from time to time during hearings that can not hire domestic help because welfare is more attractive.

Disaster could be wrought on the economy by merely redistributing less than one-half of 1% of the G.N.P. Our written statement reviews the experience of Uruguay with similar legislation. Between 1958 and 1968 inflation in all of Latin America averaged 100%. It was 1600% in Uruguay during that same period. It would be no easier for government to eradicate poverty by guaranteeing an income to the poor by redistributing a little bit of the income of the "non-poor" than it would be to let just a little air out of a balloon by picking it with a pin (see our written statement relating to Uruguay). Our research has gone behind the emotional screens and displayed facts. We believe most of the facts presented will be mindstickers.

How would the Administration's Family Assistance Plan affect the nation? In the words of Senator A. Ribicoff, "I think the country must realize that we are basically changing the social philosophy of the United States once we

put this into effect. None of us can anticipate the consequences, but we are definitely starting this nation into a new social program . . . you put 25 million people into a new social program and you are changing society—we do not know the impact that it will have on the people benefited and the people outside the program, their concepts, their reactions and what it will lead to . . .” This study suggests what some of these consequences are likely to be and gives a fore-taste of future changes and what the future cost of the welfare plan would be to the Federal Government and to society. Testimony of previous witnesses is used in painting this picture of the future. The likely immediate changes would include the elimination of the work requirement, a substantial increase in the income floor, and inclusion of single individuals and childless couples.

Heard, for example, is the Friends Committee on National Legislation spokesman agreeing that able-bodied adults that choose not to work, that do not offer themselves for hire at all, should be given an adequate income as a matter of right. Echoing these sentiments was testimony given on behalf of organizations such as the National Council of Catholic Women and Jewish Women; Church Women United; and National Consumers League. Their position: “in our judgment, it is neither necessary nor desirable that training and work requirements be mandatory. We believe that a mandatory work requirement is not needed for either men or women, and urge its deletion.” Just about every organization that supports the Act is demanding that the federal floor be raised. If this bill is passed intact, the floor is destined to rise, especially during election years. Total costs of these demands is presented, which in most case would cost more than the total after-tax profits of all U.S. corporations combined. Intangible costs of the work incentive is simulated using the experience of another country—Uruguay. The cost would be around \$300 billion—150% of the total 1970 federal budget. H.R. 1 would have the effect of wiping out millions of jobs. Study findings identify jobs and industries that would be eliminated state by state. Nearly three-fourth of a million jobs would be wiped out, for example, in New York state under Senator Javits’ amendment to H.R. 1. His amendment would also wipe out 85% of the manufacturing sector in North Carolina. Our attached statement concludes with recommendations for effective welfare reform and proposes a program of guaranteed job opportunity as an alternative to guaranteed income.

AN ANALYSIS OF THE ADMINISTRATION’S FAMILY ASSISTANCE PLAN (H.R. 1)
WITH RECOMMENDATIONS FOR EFFECTIVE WELFARE REFORM, WILLIAM H. SHAKER,
P.E., DELTA ASSOCIATES

A Research Report to the Senate of the United States:

Abstract.—The purpose of this report is to inform and to initiate public debate of the welfare issue. Our research study goes behind the emotional screens and displays facts. Most of the facts presented are mind stickers—which should be startling to many, thought provoking to most. Read with an open mind, we believe that many supporters of H.R. 1 will re-think their positions. Out of this process can come real welfare reform.

The study is presented in the format of testimony to the Committee on Finance, United States Senate. It contains a detailed and critical analysis of the Administration’s Family Assistance Plan, along with some recommendations for effective reform.

In the words of United States Senator Abraham Ribicoff: “. . . I think the country must realize that we are basically changing the social philosophy of the United States once we put this (H.R. 1) into effect. None of us can anticipate the consequences, but we are definitely starting this Nation into a new social program . . . you put 25 million people into a new social program and you are changing society—we do not know the impact that it will have on the people benefited and the people outside the program, their concepts, their reactions and what it will lead to . . .” This study suggests what some of these consequences are likely to be and gives a foretaste of future changes and what the future cost of the welfare plan would be to the Federal Government and to the society. Testimony of previous witnesses is the paint for this picture of the future. The likely immediate changes would include elimination of the work requirement, a substantial increase in the income floor (guaranteed income) and inclusion of single individuals and childless couples.

Heard, for example, is the Friends (Quaker) Committee on National Legislation spokesman agreeing that able-bodied adults who choose not to work—who

do not offer themselves for hire at all—should be given an adequate income as a matter of right. Echoing these sentiments was testimony given on behalf of organizations such as the national councils of Catholic Women and Jewish Women, Church Women United, and the National Consumers League. Their position: "In our judgment, it is neither necessary nor desirable that training and work requirements be mandatory. We believe that a mandatory work requirement is not needed for either men or women and urge its deletion." The American Civil Liberties Union testified: "Compelling a person to accept employment as a condition for receiving welfare benefits is in fundamental conflict with the principles of free society, with the 13th Amendment's prohibition against involuntary servitude and the 14th Amendment's guarantee of equal protection of the laws."

This report is intended to give the membership of the organizations that presented testimony a clear understanding of the positions taken by their leadership. Thus, this report is addressed to the concerned and interested layman and laywoman as well as governmental and industrial leadership.

Just about every organization that supports the act is demanding that the Federal floor (guaranteed income) be raised. The total cost of these demands is presented, which in most cases, would cost more than the total after-tax profits of all United States corporations combined. It is generally acknowledged that H.R. 1 contains some degree of disincentive to work. The intangible cost of this work disincentive is simulated using the experience of another country—Uruguay. The result would be a cost of around \$300 billion—one-hundred-fifty per cent of the total 1970 Federal budget. H.R. 1 would have the effect of wiping out millions of jobs. Study findings identify jobs and industries that would be eliminated—state by state. Three-fourth of a million jobs would be wiped out, for example, in New York State under Senator Javits Amendment to H.R. 1. His Amendment would also wipe out 85% of the manufacturing sector in North Carolina.

The study concludes with recommendations for effective welfare reform and proposes a program of guaranteed job opportunity as an alternative to guaranteed income.

INTRODUCTION

In studying the previous testimony presented to this committee (both on H.R. 1 and H.R. 16311), it has become clearly evident to me that this committee is asking the right questions. I don't think that you have yet come up with a pragmatic solution to the "welfare mess"—but it is also very clear that you are committed to doing so. I hope that my testimony here today and the attached written material will be of some help.

Today's industrial systems engineer is charged with maximizing the utilization of all available resources—including people—and to large extent might be considered a "social engineer". Part of his function is the creation of new jobs and job opportunities. Perhaps as a systems engineer and a citizen deeply concerned about certain trends in this country, I can add a different perspective to this legislation and provide information that will be of value during further deliberations.

THE URGENT NEED FOR REFORM

The opening remarks of Joseph C. Wilson, Chairman, Xerox, in support of the Administration's Family Assistance Plan is fairly typical:

"... we find the present system of public welfare to be demeaning, inefficient, inadequate, and with so many disincentives built into it that it encourages continued dependency. It is hopelessly bad and incapable of reform".

All sides see the need for reform. In opposing the bill, Liberty Lobby testified: "... That the present welfare system is wasteful and mismanaged is a point on which we can all agree ...".

And the Chamber of Commerce of the United States:

"... We agree with the diagnosis of the welfare problem, but we disagree completely with the proposed solution".

H.R. 1 can serve as a vehicle to truly effect welfare reform. All political perhave not yet agreed, however, on a "suitable" definition of the word "reform".

I am tired of listening to criticism from people who are not able to offer constructive alternatives. Hopefully, I am not guilty of this omission.

Before H.R. 1 can be used as a framework for welfare reform, two fundamental changes must be made in the bill:

1. Remove the principles of guaranteeing an income as a matter of right.
2. Remove the principle of the negative income tax.

The discussion which follows is intended to make evident why these two changes to H.R. 1 are so essential for reform and why I have concluded that passage of H.R. 1 with the negative income tax and guaranteed income provisions intact will block effective reform forever.

H.R. 1 IN ITS PRESENT FORM—AND A PREDICTION OF THE FUTURE

This bill must be studied—not the way that it reads today—but the way that suasions are virtually unanimous in saying that the need for reform is urgent. All your best judgment says that it will read in the future.

Exhibit 1 illustrates the cost effect of several amendments that have been proposed. I have great difficulty grasping the meaning of \$100 billion. I have therefore shown, as a reference line, the projected total after-tax profits of all United States corporations for 1971.

I suggest that the cost of H.R. 1 in the future will be one of the higher points.

I have come to this conclusion, both from examining the trends of governmental spending and studying the testimony of previous witnesses, that this committee has called to testify.

The projected cost of H.R. 1 along with the growth of the personal income tax and social security is shown in exhibit 2.

There was much debate in Ways and Means in the year 1913 as to the advisability of putting a limit of 10% maximum on the income tax bill. The major argument against such a limitation was that the rate would never reach that level and that it was silly to worry about such things.

One of the objectives of the Social Security Act was to relieve poverty and distress through contributory programs in such a way that relief could be gradually tapered off to negligible levels. The government was to get out of the business of relief. In a message to the Congress in 1935, Franklin D. Roosevelt declared:

“... The Federal Government must and shall quit this business of relief ... Continued dependence upon relief induces a spiritual and moral disintegration, fundamentally destructive to the national fiber...”

As with the Administration's guaranteed annual wage proposal, Social Security was enacted on the premise that it would make direct relief unnecessary and so displace it. That, of course, did not happen. Direct relief has grown steadily—despite growing prosperity. Social security benefits have been increased continually—especially during election years—new programs have been added and expanded and the coverage constantly widened.

Past actuary for the Social Security Board, W. Rulon Williamson has estimated Social Security liability (not including Medicare) to the families of those paying social security taxes—but not yet retired—to be \$1 trillion.

The cost of social welfare in the United States is growing at an annual rate of about 14%. In 1970 the money spent in the United States by all levels of government for social welfare amounted to \$143 billion. Spread on a per family basis, this amounts to \$2650 for the typical American family. The proposed welfare cost increases under H.R. 1 would be on top of this amount.

I will now describe the probably future welfare picture—if H.R. 1 (with guaranteed income and negative income tax provisions intact) is enacted—based on highlights from testimony given to this committee on H.R. 16311 and Administration testimony on H.R. 1.

SOCIAL PHILOSOPHY CONTAINED IN H.R. 1

I think that the meaning of H.R. 1 is succinctly expressed in a statement by Senator Ribicoff.

“... I think the country must realize that we are basically changing the social philosophy of the United States once we put this [H.R. 1] into effect. None of us can anticipate the consequences, but we are definitely starting this Nation into a new social program ... you put 25 million people into a new social program and you are changing society—we do not know the impact that it will have on the people benefited and the people outside the program, their concepts, their reactions and what it will lead to...”

HEW cost estimates assume that a sizable proportion of the people eligible for benefits will not apply. Secretary Richardson has estimated that perhaps 50% of the people eligible under current law have not applied. But there is still a certain social stigma attached to going on welfare. Many people are too proud to accept welfare. H.R. 1 is designed to change that. Somehow it will legislate “dignity” to those on welfare.

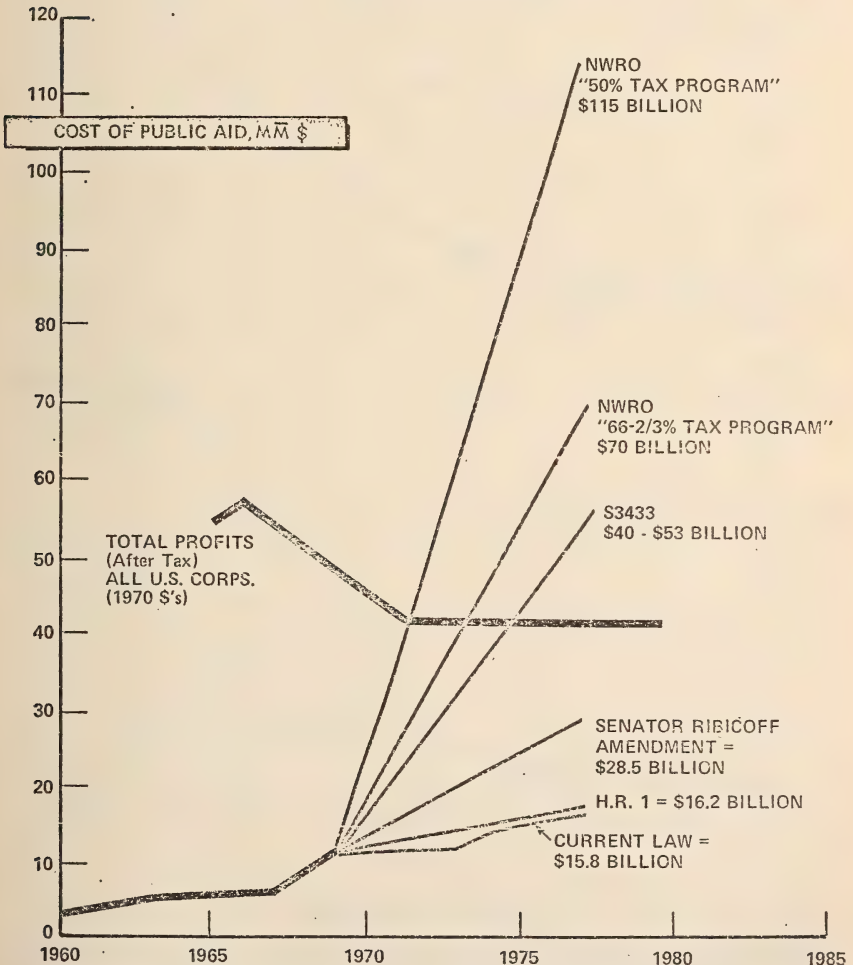
What this legislation would accomplish, in the words of its chief architect, Dr. Moynihan "... is provide income as a matter of right."

Once a guaranteed income or income supplement is declared to be a right under the law, it is doubtful if very many people will refuse it. I am sure that N.W.R.O. and O.E.O. lawyers would be able to supply adequate information for those people who would not otherwise completely understand their new rights.

I have plenty of friends—professional people and tradesmen—who are opposed to this legislation. But if it passes they will be looking forward to taking advantage of it when benefits get up to where they can receive an "adequate" income.

Much of the testimony has supported this legislation—but only as a beginning. Dr. Roy Nicks, Chancellor, University of Tennessee, and President, American Public Welfare Association, stated "... This legislation will establish a base upon which further improvements can be built." This same thought permeated much of the testimony and has also been carried in the popular press. To quote Time Magazine, "... it remains a firm, if modest first step in the right direction."

WHAT WOULD THE COST OF PUBLIC AID MEAN IN THE FUTURE?



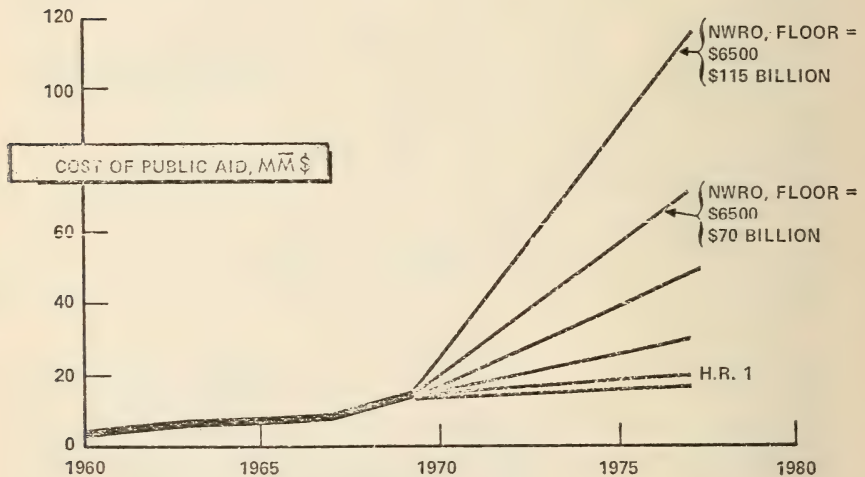
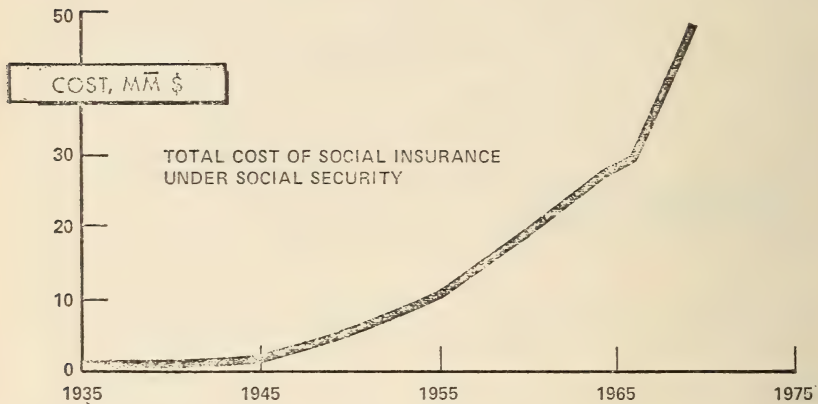
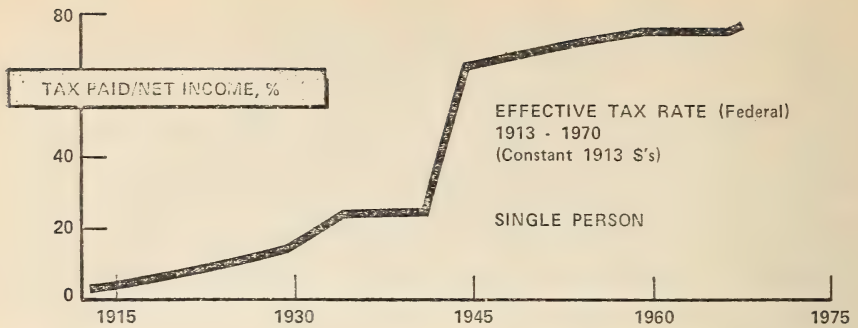


Exhibit 2

WORK REQUIREMENTS

There has been much heated discussion over the work requirement and whether work ought to be suitable.

H.R. 1 would require that able-bodied recipients register in the Opportunities for Families program of the Department of Labor. Secretary Hodgson estimates

that this program would register about 3 million persons for training and job opportunities. The past track record for programs of this nature has proved to be only 10% effective.

As a point of clarification, the requirement that the potentially employable seek work or job training to remain eligible already exists—as you know—in many of the states. Perhaps it was included to make the bill more acceptable to the working man who must assume the obligation of providing an adequate, guaranteed income to the man that does not work.

But to remove any doubt, many people would like to have any mention of work requirements removed from the bill.

Take, for example, the testimony of Edward T. Anderson, representing the Friends Committee on National Legislation.

The Friends Committee was completely opposed to the work requirement. Work should, of course, be optional if the recipient would elect to work.

Mr. Anderson was asked, "What do you recommend in reference to the individual able-bodied adult, who chooses just not to work at all, doesn't offer himself for hire at all? Are you for a program that would give a federally assured income to that person as a matter of right? Answer: "Yes. As long as a person is alive there are certain basic needs he has . . . he still has to eat . . . shelter . . . clothes." Question: "These needs must be met—even if this able-bodied adult chooses not to work?" Answer: "Yes."

The next statement represents the position of the following organizations: National Council of Jewish Women, National Council of Catholic Women, National Council of Negro Women, Church Women United, The National Board of Managers, National Consumers League—

"In our judgment, it is neither necessary nor desirable that training and work requirements be mandatory. We believe that a mandatory work requirement is not needed for either men or women and urge its deletion."

During its testimony, Common Cause seemed quite irate that the "suitable work" language was deleted from the original house bill. Common Cause testified that a recipient should be allowed to refuse work where the pay is less than the prevailing or minimum wage—whichever is higher. Common Cause wants mothers with school age children to be exempted from the work requirement.

A very strong force in this country is the American Civil Liberties Union. Their position is the following:

"Compelling a person to accept employment as a condition for receiving welfare benefits is in fundamental conflict with the principles of a free society, with the 13th Amendment's prohibition against involuntary servitude and the 14th Amendment's guarantee of equal protection of the laws."

WHAT WOULD THE GUARANTEED INCOME BE IN THE FUTURE?

Many organizations—some of them with a real and immediate interest, such as the National Welfare Rights Organization—have recommended—some demanded—that the income floor be raised far above the \$2400 per year that is presently proposed.

Many members of the United States Senate would also vote to raise the floor. The amendment of Senator Javits, for example, would redefine the poverty level at \$4800 for a family of four. His basic amendment phases in this redefined poverty level with the Federal government handling the entire welfare system by 1979. If a nominal inflation rate of 4% in the cost of living is assumed, the Senator's poverty level would be \$7100 in 1979.

A large number of witnesses have called for the poverty level to be redefined as that amount to provide a minimal low standard of living. What is that? The Bureau of Labor Statistics estimates this to be \$6567 for a family of four. It might be of interest to note that the poverty level for "minimum subsistence" for a family of four has risen 61% in constant 1970 \$'s between 1941 and 1969. (In 1941 the poverty level for a family of four was \$836¹ or \$2570 in constant 1970 \$'s).

A number of national leaders have urged that the floor be moved up to the poverty level (\$4116 in 1971 \$'s). Mayor John Lindsay thinks that the floor should be moved to at least the poverty level and that the cost of living increase principle be applied to it. Mr. Lindsay supports current legislation because being—in his words—"a practical politician," he does not see any chance in moving it [the \$2400 minimum] up at this time.

¹ "Poverty and Affluence, The 20th Century Fund," p. 148.

From the Business community you heard testimony from Joseph C. Wilson, Chairman, Xerox Corporation, and C. W. Cook, Chairman, General Foods. The position taken by these gentlemen was as follows:

"At the present time we support the proposed uniform national level of income maintenance for a family of four. We believe, however, that inasmuch as minimum income of [\$2400] for a family of four hardly provides a subsistence level of income, a priority claim against future available Federal funds should be invoked to raise total assistance to more acceptable levels."

In its testimony, the Friends Committee on National Legislation supported the floor recommended by the White House Conference on Food, Nutrition and Health in 1969. This amount, adjusted for inflation in the cost of living, would be \$6011 in 1971.

The National Welfare Rights Organization (NWRO) has proposed the benefit level for a family of four be set at \$6500 per year.²

Adjusting this figure for cost of living (assuming 4%) would bring this to \$8900 by 1979. NWRO demands that their guaranteed income be adjusted for productivity increase in the economy as well as for inflation. This would bring their guaranteed income to \$10,000 by 1979.

This kind of discussion probably seems like fantasy to the typical American who works for a living. And it might be sluffed so deadily serious in demanding from society what they believe to be their right and because NWRO is developing an ever widening circle of support.

With a membership in excess of 100,000 NWRO could be a powerful force in getting changes made in the law that they want. Many "establishment type" organizations are in complete sympathy with NWRO demands. National Council of Jewish Women, National Council of Catholic Women, National Council of Negro Women, Church Women United and the Womens Division of the United Methodist Church are among those that support NWRO demands.³

Because of what they consider to be political reality, however, most of these organizations tend to support a lesser amount and recommend that the proposed amendment of Senator Javits—a poverty level of \$4800 be initially accepted. This would be for starters. They recommend that periodic revision of the poverty definition be made thereafter in light of subsequent price rises and general productivity and income advances, and the increasing capacity of the economy to meet the needs of all Americans.

In other words, all Americans, as a matter of right, even those able-bodied Americans who choose not to offer themselves for hire should share in the productivity improvement of those of us that do choose to work.

Does it not occur to these people that under those conditions an increasing number of us will decide to flee the work scene?

The point that I am trying to make is this: Once this new kind of philosophy is legislated there will be no end to the pressures to increase the benefits—especially during election years.

SINGLE INDIVIDUALS AND CHILDLESS COUPLES

Parallel to the efforts to increase the minimum guarantee will be a drive to include single individuals and childless couples in the program.

The spokesman for Common Cause testified ". . . excluding individuals and couples without children is a cruel and discriminating practice towards these people in need." Common Cause demands uniform "adequate" assistance—including needy individuals and couples without children.

In the words of Edward T. Anderson, representative of the Friends Committee on National Legislation, ". . . [The Administration program] incorporates only limited application of new principles and falls far short of needed changes . . . The completely arbitrary decision to exclude single persons and childless couples betrays a cruel indifference to their plight."

John Lindsay testified that exclusion of impoverished single persons and childless couples from the Federal program is one of its shortcomings.

Mr. Wilson of Xerox also recommended the inclusion of single persons and childless couples. He also believes that neither training nor work should be made a condition for continuance of public assistance to women heads of households.

From the American Association of University Women came this statement: "In the eyes of our members a principle shortcoming of the House bill is its failure to

² Secretary Richardson—Hearings on H.R. 1, Aug. 2, 1971.

³ Testimony on H.R. 16311, p. 1403, 2297.

cover the single poor and impoverished childless couple . . . Are we justified in speaking reform if one-third of the deprived are excluded from this so-called bill?" And so it goes.

Based on this level of support, it seems safe to conclude that once the concept of guaranteed income is legislated, the bill will be expanded to include single persons and childless couples.

Let us take a long, hard look at what the probable effect of this would be.

The 1971 definition of the poverty line for a single individual is \$1996. That is higher than the 1967 per capita incomes in four states (Kentucky, Mississippi, Virginia, and Georgia).

At the age of 18, I personally would have loved to have been a beach comber if someone like the Federal Government were to have paid me for it.

This provision would most certainly encourage proliferation of the "hippie commune" subculture. Marriage would certainly be discouraged as the guaranteed income for two individuals, at the poverty level, would be \$3990. The figure would be \$2400 for a married couple.

ERRORS IN LOGIC—THE NEGATIVE INCOME TAX DILEMMA

On August 2 Secretary Richardson demonstrated a gadget that quickly shows the effect of various income maintenance schemes. HEW is fighting for the passage of H.R. 1. Therefore I am not sure why they built the gadget because their gadget demonstrates the theoretical infeasibility and complete unworkability of any program based on the principles underlying H.R. 1.

In any negative income tax scheme, as the guaranteed income floor is raised up closer to what might be defined as an income necessary to supply the basic needs of the poor—the level of income at which some welfare supplement is received rises sharply. It becomes advantageous for the marginal worker to leave work and go on welfare. The income disregard must be increasingly higher to overcome the incentive to drop out, etc., The program is self-defeating.

The gadget clearly demonstrated the dilemma of this legislation. Either it is completely inadequate at the lower end of the scale of earnings—or it is highly excessive at the upper end. If you assume a negative tax of 50%, it must pay only half an "adequate" income (by its own definition of "adequate") to a family that earns no income or it must pay nearly twice an "adequate" income to a family that already earns an almost adequate income.

This problem can be reduced by changing the disregard formula from allowing a recipient to keep one dollar for every two earned to allowing him to keep only one dollar for every three earned.

But this creates the problem of not providing sufficient incentive to entice a person to continue working.

The negative income tax concept also creates serious inequities between working families on welfare and working families not on welfare. Let me illustrate this with an example of how the income disregard formula can work in Michigan under present law.

H.R. 1 would do nothing to improve the situation, ". . . in an extreme case, a family of four earning \$310 per month (\$3720 per year) would not be eligible for assistance. Another family, initially with no income, receives a welfare payment of \$305 per month (\$3660) annually. Subsequently, the latter family head obtains a job paying \$310 a month, which combined with the reduced welfare payment of \$158 provides a total monthly income of \$468 (\$5616 yearly). Additionally, this latter family is entitled to free child care and full medical services, while the former is not. The inescapable conclusion is that by attempting to make work more attractive to Aid to Dependent Children recipients income disregard programs also make Aid to Dependent Children more attractive to the working poor."⁴

The problem is brought into even sharper focus in the Finance Committee staff report—Appendix B of the H.R. 1 hearings.

The equivalent "tax rate" increases from 49% to 112% when annual earnings increase from \$1000 to \$1001 for a family of 4, in Wilmington, Delaware. The report goes on to point out that each dollar earned over \$5,000 would cost this family \$1.33 in Chicago.

⁴This example is taken from "Council Comments," Citizens Research Council of Michigan, Robert E. Pickup, executive director, July 9, 1971.

REGIONAL EFFECTS

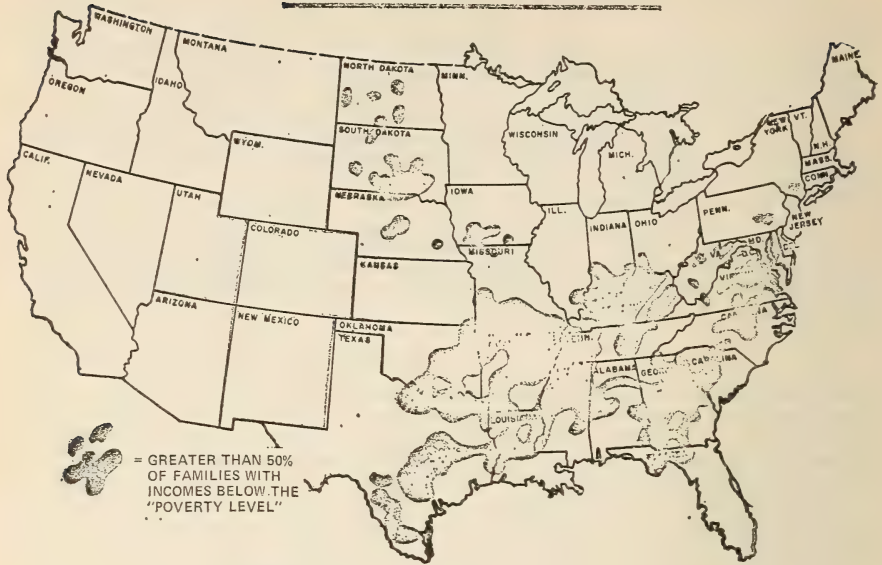


Exhibit 3

REGIONAL EFFECTS

More than 50% of the families in the shaded areas in exhibit 3 have incomes less than the "poverty level" and would be receiving welfare payments under H.R. 1. These blotches on the map will surely grow as our productive drive is marasmically weakened. The affect on the working man as well as the crippling of industry can be forecast with some degree of certainty.

What is the affect of H.R. 1 on people who are not on welfare and are working alongside a man that is drawing welfare subsidy? This should be carefully examined—with the following facts in mind. What kind of Utopia would H.R. 1 bring?

In response to a question from Senator Ribicoff, Secretary Hodgson furnished a chart which indicates by state the wage levels required to get off welfare. Comparing these data with average (before tax) hourly earnings (1970) for the various states reveals that the wage level at which a person could still receive welfare payments under H.R. 1 is higher than the average hourly earnings in 15 states. (These states are: Connecticut, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, Rhode Island, Pennsylvania, South Dakota, Vermont, and Virginia.)

There is a strong possibility that H.R. 1 would wipe out complete industries and millions of jobs. Work requirements will, I believe, eventually be written out of the legislation. Even if the work requirement were retained, it is maintained that it would not (and could not) be enforced—based on the following premises:

Premise 1. Given a strong enough incentive, the average worker can figure out a way to lose his job without quitting.

Premise 2. Given a strong enough incentive, the average worker can make himself available for employment and continue to seek employment without ever actually getting a job.

If the above argument is accepted, the effect of the guaranteed annual income would be to cripple the American economy. The effort would be different in different states because of regional differences in pay rates and type of industry.

I analyzed the affect that H.R. 1 would have on several key industries on a state-by-state basis for four different minimum guaranteed incomes:

Case 1: H.R. 1 (\$2400, assumes state supplements continue at present levels).

Case 2: Poverty level (\$4116).

Case 3: Senator Javits' amendment (\$4800).

Case 4: NWRO demand (\$6500).

The results of this analysis are shown in exhibits 4 through 7. The industries and jobs that pay less than the guaranteed income (and which would be presumably wiped out) are indicated with a dot. (The analytical backup for these charts is contained in the attached Appendix).⁵

For example, exhibit 4 shows that at the H.R. 1 floor for Alabama (\$2400), waiter and waitress jobs pay less than the guaranteed income. At the poverty level (exhibit 5), jobs in the apparel industry are below the income floor as are all jobs in the "clerical/other" section of the chart with the exception of deliverymen, insurance agents, secretarial and wholesale trade. As the guaranteed income floor moves up to the level proposed by Senator Javits (\$4800.) in exhibit 6, you can see that the floor for Alabama is above the wages paid in apparel, food products, textile mills, and weaving mills. The floor of \$4800. is also above the wages paid in all jobs shown in the "clerical/other" section of the chart. At the NWRO demand (\$6500.), exhibit 7 shows the floor for Alabama would be greater than the wages paid in: apparel, chemicals, fabricated metal products, food products, printing and publishing, textile mills, and weaving mills. This NWRO demand is also greater than wages paid in all jobs shown in the "clerical/other" section of the chart.

The average spendable income for the average production or non-supervisory worker on private payrolls is only \$1500 per year more than the guaranteed income would be at the poverty level (\$4116.). It is likely that many people with after tax incomes that are only marginally above the guaranteed income would find it not worth their while to work at all. This effect is not shown on the charts. In constructing them, I included only jobs that pay less than the stated guaranteed annual incomes. Even on this basis, the effect would be economic paralysis.

One-half million jobs would be wiped out in the state of New York under Senator Javits' amendment. The affect of setting the floor at the poverty level would wipe out 60% of all manufacturing jobs in Mississippi and 70% of the manufacturing sector in North Carolina. 85% of the manufacturing sector would be wiped out in North Carolina under Senator Javits' amendment.

I offer just one example of secondary effect of such a collapse—our balance of payments. Apparel, which is one of the industries to be essentially wiped out at the poverty level, exported goods totaling \$200 million last year.⁶

I have tried to demonstrate that these "income as a matter of right" schemes will affect a much broader part of the economy than that depicted by the lady that Senator Long has referred to from time to time during the course of the testimony that can not hire domestic help because welfare is more attractive. This disaster could be wrought up by merely redistributing less than one-half of 1% of the GNP. Guaranteed annual income legislation will not, as many have implied during these hearings, bring Utopia. To the contrary, it could, as I have attempted to demonstrate in exhibits 4 through 7, result in an infusion of carcinogenics into the lifeblood of our economy.

THERE IS NO FREE LUNCH—GOVERNMENT CANNOT ELIMINATE POVERTY

The thrust of much of the testimony has been geared at what government must do to eliminate poverty. What level of income should government guarantee; should work be required; should single individuals be included?—and so on.

But more fundamental is the question: Can government eliminate poverty by redistributing a small fraction of the disposable income of those not in poverty? The answer is a resounding no. Perhaps the elimination of poverty can be approached in this country—but not this way. Poverty will never be wiped out by severing the link between effort and reward.

Several governments have committed themselves to eliminating poverty. They have all failed—e.g., England, Uruguay. It is logically impossible for government to eradicate poverty because all such government schemes to do so are self-defeating. They progressively reduce incentive.

The elimination of poverty implies the creation of wealth. Government cannot create wealth—it can only redistribute it. But, it is said so repeatedly, this country should be able to eliminate poverty if it has been able to place a man on the moon. Out of this notion has grown—what I believe to be—a great deal of fuzzy thinking.

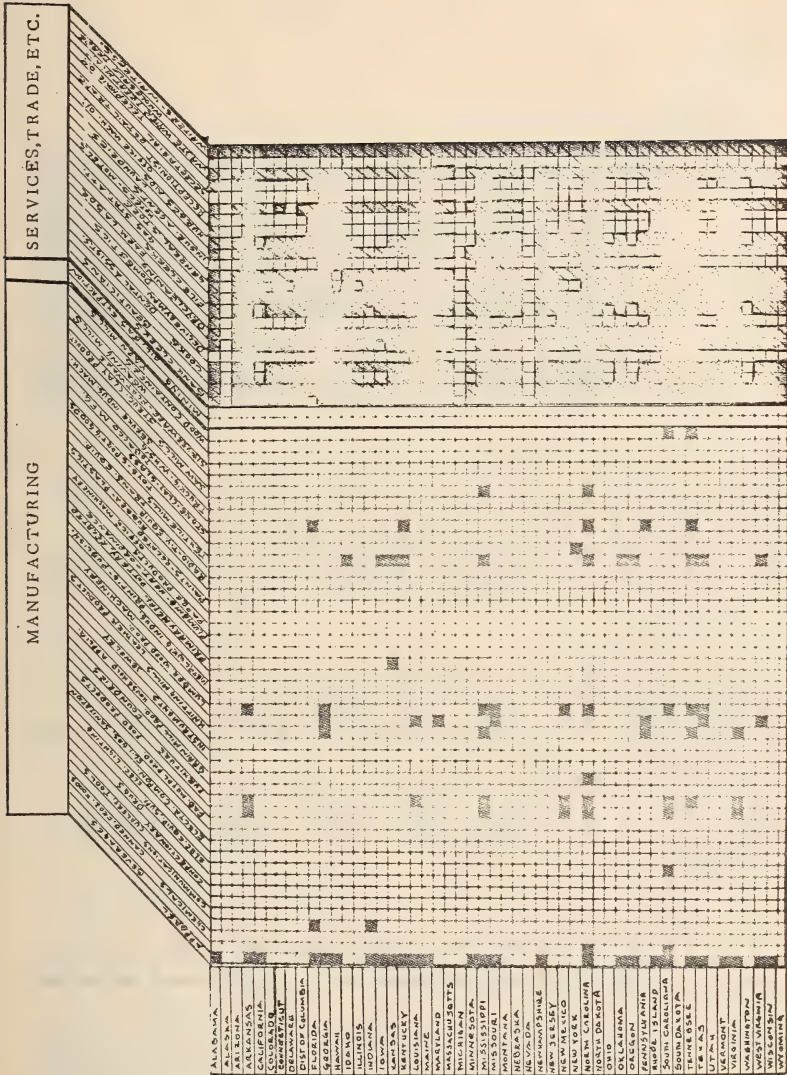
⁵ The source data for this analysis is earnings data published by the various states and earnings and employment data published by the U.S. Bureau of Labor Statistics.

⁶ "Business Week", Sept. 18, 1971.

	MANUFACTURING	SERVICES, TRADE, ETC.
ALABAMA		
ALASKA		
ARIZONA		
ARKANSAS		
CALIFORNIA		
COLORADO		
CONNECTICUT		
DELAWARE		
DISTRICT OF COLUMBIA		
FLORIDA		
GEOORGIA		
HAWAII		
IDaho		
ILLINOIS		
INDIANA		
KANSAS		
KENTUCKY		
Louisiana		
MAINE		
MARYLAND		
MASSACHUSETTS		
MICHIGAN		
MINNESOTA		
MISSISSIPPI		
MOORE		
NEBRASKA		
Nevada		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Carolina		
North Dakota		
Oregon		
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee		
Texas		
Vermont		
Virginia		
Washington		
West Virginia		
Wisconsin		
Wyoming		

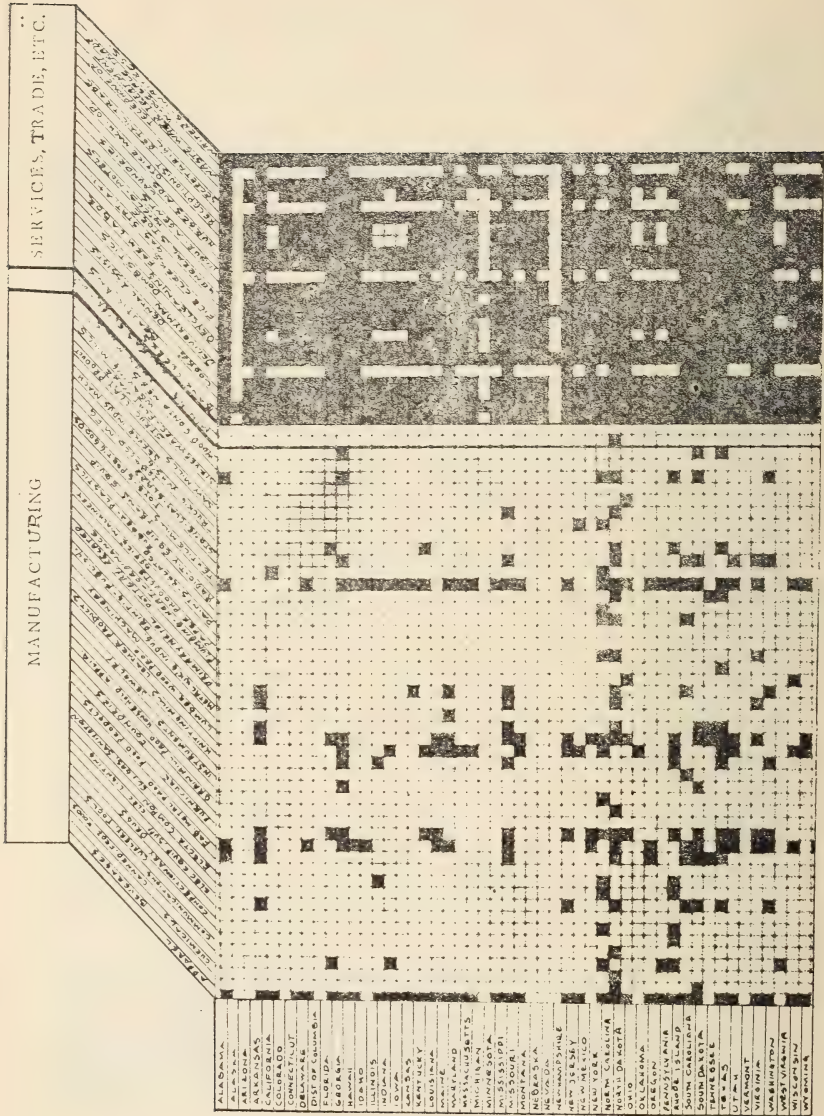
CASE 1 (\$2400 + state supplements)

Exhibit 4



CASE 2 (Poverty Level)

Exhibit 5



MANUFACTURING		SERVICES, TRADE, ETC.	
ALABAMA			
ALASKA			
ARIZONA			
ARKANSAS			
CALIFORNIA			
CONNECTICUT			
DELAWARE			
DIST. OF COLUMBIA			
FLORIDA			
GEORGIA			
HAWAII			
IDaho			
ILLINOIS			
INDIANA			
IOWA			
KANSAS			
KENTUCKY			
LOUISIANA			
MAINE			
MARYLAND			
MASSACHUSETTS			
MICHIGAN			
MINNESOTA			
MISSISSIPPI			
MISSOURI			
MONTANA			
NEBRASKA			
NEVADA			
NEW HAMPSHIRE			
NEW JERSEY			
NEW MEXICO			
NEW YORK			
NORTH CAROLINA			
NORTH DAKOTA			
OHIO			
OKLAHOMA			
OREGON			
PENNSYLVANIA			
RHODE ISLAND			
SOUTH CAROLINA			
SOUTH DAKOTA			
TEXAS			
UTAH			
VERMONT			
VIRGINIA			
WASHINGTON			
WEST VIRGINIA			
WISCONSIN			
WYOMING			

Case 4 (N. W. R. O. \$ 6500)

Exhibit 7

But, as some have asserted, it is so easy. All government need do is re-distribute a small proportion of disposable income. A study conducted by the New School of Social Research⁷ has demonstrated that all persons could be brought above the "minimum adequacy" level (about \$6500 in today's dollars) by redistributing 13.6% of the disposable income of "non-poor" Americans. It was concluded then (1966) that such a redistribution would not be politically feasible and would probably occasion violent opposition. They then went on to calculate what percentage of disposable income must be redistributed to eliminate "abject poverty"—i.e., raise everyone's income above the poverty level. That turned out to be about 3 per cent of the disposable income of those not in poverty. They concluded that this would be not only feasible but easy.

It would be no easier for government to eradicate poverty by guaranteeing an income to the poor by redistributing a little bit of the income of the "non-poor" than it would be to let just a little air out of a balloon by pricking it with a pin. This is pointed out rather graphically in the following example.

AN UGLY SCENARIO OF THE UNITED STATES—15 YEARS FROM NOW

A senior member of the management community suggested that a precursor of what the United States is in for if H.R. 1 is passed might be gleaned from a nation that tried to eliminate poverty using similar philosophy to that contained in H.R. 1. Perhaps we might learn from another country's experience with governmental welfarism. The case selected was Uruguay.

The Uruguayan is typically of European origin. Uruguay's literacy rate is one of the world's highest—91 per cent; it has South America's lowest population growth: 1.4%. In the middle fifties Uruguay was distinguished for her high living standard, with a per capita income nearly double the average for all of Latin America and comparable with the per capita income of Ireland, Italy and the Netherlands—and about double that of Japan. (The relative growth in real per capita income of Uruguay is shown in Exhibit 8).

Some fifteen years ago, Uruguay launched an all-out campaign to eliminate poverty. They hoped to do this through greatly expanded social welfare and governmental programs.

Approximately 45 per cent of the population is now dependent on the government for their total income—consisting mainly of government jobs and government provided programs such as family allowances (guaranteed annual income). All of this has been paid for with extremely high taxes and deficit spending. Approximately 50% of the industrial payroll costs are paid to the government for social insurance programs. Yet taxes have not been sufficient to pay the bill of the ever spiraling cost of this welfare state. This has meant huge deficits—thus skyrocketing inflation.

During the period 1963–1968 the inflation of consumer prices in Uruguay rose 1600%. This compares with a 16% rise in the United States and an average rise of 100% for the remaining Latin American countries.

Unemployment has climbed to over 30 per cent and demands for more governmental benefits continue.

In efforts to halt inflation, the government declared a freeze on wages, prices and dividends in mid-1968. Inflation now seems to be somewhat in check—but problems worsen. About half of the "work force" has continued on and off 24 hour work stoppages in protest against the freeze. Many establishments, including private hospitals, were closed for violating the wage-price freeze.

From the New York Times of January 21, 1969:

"... Striking government employees rioted in downtown Montevideo today, smashing windows, setting up flaming barricades and sending tourists fleeing in panic. ... The police fought back with tear gas, high-pressure water hoses and clubs ...

The striking civil servants were demanding payment of monthly salary bonuses of \$24.00, which they say is two months overdue."

It seems that the conditions in Uruguay will not be reversed. It appears to be politically infeasible because the people are not willing to let any of the many social programs of government be trimmed back.

Ever since a Marxist was democratically elected president of a Latin American nation, observers have been increasingly aware of the possibility of a radical change at other national polls. According to the July '71 issue of *Business—Latin*

⁷ "Poverty and Affluence, The 20th Century Fund," 1966.

INCREASES IN REAL PER CAPITA INCOME
CONSTANT 1958 \$'s
(1950 - 1969)

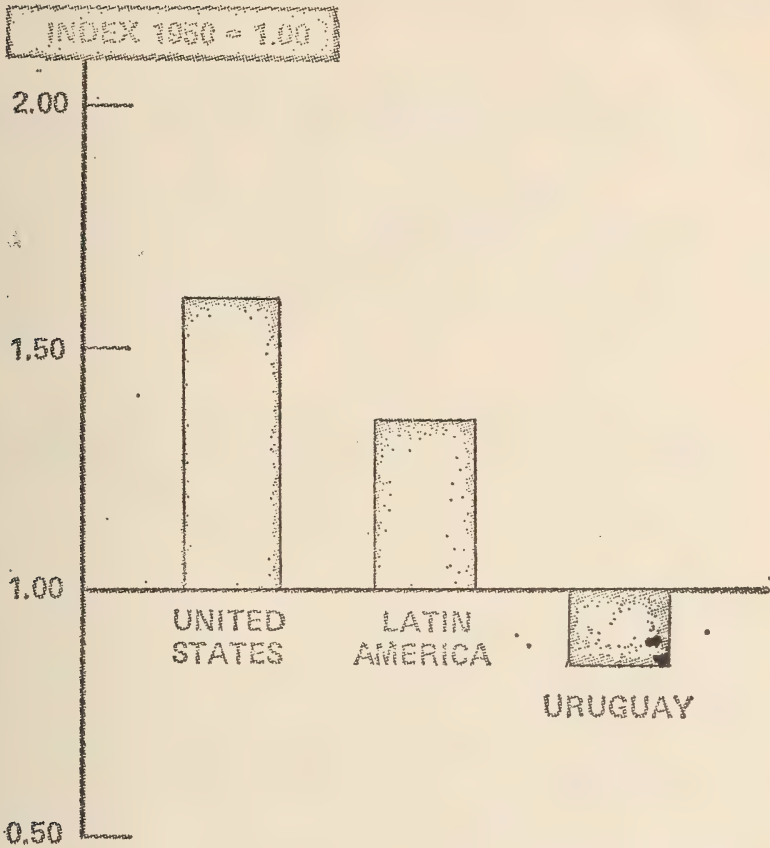


Exhibit 8

America, it now seems likely that President Jorge Pacheco Areco will not retain his office—and that Uruguay will go the way of Chile.

A mind sticking question: would it be possible for guaranteed income legislation designed to eliminate poverty (H.R. 1 in its present form) to put America on the same course? A sobering thought—I do believe!

As Sterling Slappey points out in *Nations Business*⁸—“Until [just 15 years ago Uruguay] called itself ‘The Switzerland of Latin America’ because its people were so industrious, busy and neat. Montevideo is now one of the world’s filthiest cities outside the Orient. The people have so little pride left they litter their streets with paper and dump their nastiest garbage on the curb.”

⁸ “*Nations Business*”—April 1967.

This, then has been the result of a political and economic system which no longer requires its citizens to produce an honest day's work—a system which guarantees an adequate income as a matter of "right."

In his August 6 speech on the Senate floor opposing the guaranteed wage provision of H.R. 1, Senator Long concluded with:

"... Uncle Sam will not be the inspiration of the free world while the major cities of America are clogged with trash and pollution and the tax-paid welfare loafers wallow in litter and debris."

WHAT IS THE COST OF THE WORK DISINCENTIVE?

Frequently, throughout the hearings, the question has been raised as to the intangible cost of the work disincentives contained in negative income tax legislation. I have attempted to simulate this effect by using Uruguay's experience as a model.

Recent U.S. productivity increases have averaged 2.5% per year (it was 5% in 1962). Based on a productivity increase of 2.5%/year and in constant 1970 \$'s, U.S. per capita income should reach \$4483 by 1977. On the other hand, if we use Uruguay as a model, our productivity would decrease by approximately 1% per year. In that case, 1977 per capita income would drop to \$3396. A net loss of \$1087 per capita, or a total cost in 1977 of \$243 billion. Add to this an actual cost of the welfare payments, and we are talking about a program that will cost the American people around \$300 billion—one hundred fifty per cent of the total 1970 Federal budget.

JOB PROVISIONS

H.R. 1 provides for about 400,000 training opportunities that will move people through training and *theoretically* into private jobs. In my opinion, this portion of the program will be ineffective. What mechanism works to cause people to be trained for the right job? I don't believe there is one. Judging from the track record of the Department of Labor makes one rather pessimistic.

You are all familiar with the Auerbach Corporation study that was performed for the Ways and Means Committee. This study analyzes the performance of WIN (Work Incentive Program), whose work incentive features closely parallel those of H.R. 1.

In fiscal 1969 less than 4% of the budget appropriated under WIN for on-the-job training was spent. It dropped to about 3% in 1970. And OJT seems to be the only practicable portion of the program.

Unfortunately, in most cases, institutional training and special projects have not resulted in jobs either.

The Auerbach study stated that there has been little investigation of labor markets to determine where and how jobs can be obtained and concludes that it will probably be impossible for many WIN participants to find jobs. It would seem that the main affect of these government training programs is the creation of deeper levels of frustration and despair.

H.R. 1 would earmark \$2.2 billion for jobs, for manpower development and for supporting job placement services.

Senator Bennett and others have shown concern regarding the job provisions of H.R. 1. "It seems to me that we may be wasting our time and our money if we set up elaborate day care centers, if we set up elaborate training programs, but if at the end of the road there are no jobs . . ."

I think that in its attempts to provide jobs, H.R. 1 is only repeating past mistakes. Of the 362,000 persons trained for work under Federally funded and administered training programs, only about 10% have been placed in jobs. H.R. 1 would require that an estimated 3 million people register for training in the Opportunities for Families program. Based on past performance and the many fold increase in cases, is there any reason to believe that things will work any better in the future? Isn't it about time that we came up with new and more creative approaches to this problem?

THE NEED FOR MORE PRODUCTIVE JOBS

The continued growth of welfare and non-productive governmental spending discourages productivity. U.S. productivity growth was 5% in 1962. It has dropped to 1.3% in 1969—the lowest of 9 competing nations in the free world. This situation is taking on immediate urgency as the United States is finding it in-

creasingly difficult to compete in the world market place. Evidence the emergency 10% tariff on imports.

A solution to this problem would be to provide opportunity for our non-productive and marginally productive people to become fully productive. This would also, by the way, come close to eradicating poverty in this country. Implementation of this solution will be difficult—but not impossible.

It is estimated that it would require approximately 10 million new jobs to accomplish this.⁹

Can government create 10 million useful and needed public service jobs?

Doubtful, since that number would come close to equaling the entire payroll of all governmental units in the United States (local, state and federal). In any case, that solution would do little to improve real productivity of this country.

A better answer would be to develop the majority of these jobs in private industry. Definite legislation must be written to give the American businessman the incentive to do this on the massive scale that is required.

Recognized management authority, Peter Drucker, has estimated that between 20% and 30% of the manufacturing assets owned by American companies are outside of this country. As an example, Remington Rand Division of Sperry Rand makes two-thirds of its manual typewriters in Italy and South America, and recently shifted all of its calculator manufacturing from the United States to Japan. The Singer Company manufactures its middle and low-priced sewing machines in Italy and Britain.

Some way must be found to get industry to put poor Americans to work in such a way that is competitive (the answer is not protective tariffs).

Although large corporations are generally acknowledged to be a major storehouse of the special capabilities required to solve national problems such as those associated with poverty, a way to tap it has not yet been implemented.

The major thrust of business has been through JOBS program of the National Alliance of Businessmen.

NATIONAL ALLIANCE OF BUSINESSMEN

Compared with job training programs run by the Department of Labor, the N.A.B. JOBS (Job Opportunities in the Business Sector) program has been quite effective.

The National Alliance of Businessmen job training program was launched in 1968. The Federal government pays part of the training costs, which vary depending on the job. To date 72,570 companies have participated in N.A.B. After approximately 3½ years of operation and through the first quarter, 1971, 266,000 persons were working in N.A.B. found jobs. This is 35% of President Nixon's goal of 614,000 jobs by June 1971.

Although 266,000 jobs is far short of the number of jobs required, it is a much better record than turned in by programs run and managed by government agencies.

Programs such as this will only make a small contribution in relation to those jobs needed. And when times are hard, financially beleaguered firms cut back on the social front. Last year (1970), for example, Chrysler cancelled a \$13 million contract to train 4,500 workers. This was done just as Chrysler chairman, Lynn Townsend, was about to become chairman of N.A.B.

A much more massive program that would be tied directly to the profit and loss yardstick is needed. It will require a much higher level of cooperation between government, business and labor than we have had in the past.

SENATOR LONG'S PROPOSAL FOR SUBSIDIZED JOBS

Senator Long has proposed—as an alternative to the negative income tax approach—that an individual's wages be supplemented on an hours-worked basis. Senator Long's example follows.¹⁰

"For example, suppose a father is earning \$1.20 an hour. We might decide to supplement his wages by 40 cents an hour for up to 40 hours a week. With this approach, he would start receiving an additional \$16 for each week in which

⁹ Unemployed=4 million, incomes under \$1,000=.65 million, incomes \$1,000 to \$2,000=5 million.

¹⁰ Senator Russell B. Long. Address on Senate floor, Aug. 6, 1971.

he works 40 hours. He would receive \$8 if he works only 20 hours, and he will receive no benefit at all if he works zero hours. This is in direct contrast to H.R. 1, under which he would be paid the most in welfare benefits if he works not at all, less if he works 20 hours and least if he works 40 hours."

The principle of this proposal seems to be: guaranteed earning opportunity as opposed to guaranteed income.

This principle is sound—I question the approach.

For this approach, I believe, contains a fundamental defect. The supply and demand mechanism will be upset when you tamper with it on the massive scale proposed. Assume that you subsidize all jobs paying less than \$1.60/hour (this would include workers in variety stores, family clothing stores, restaurants and hotels). What would this mean for the employer who is now paying \$1.60? By lowering his pay rate to \$1.20 he would not be reducing the pay of his employees. He would merely be forcing the Federal government to pick up 25% of his payroll costs. And what about the employer paying \$1.20/hour? From his viewpoint, should he not also cut the rate of his workers and let the Federal government pick up the difference? A \$1.60 subsidy cutoff was used in this example, but this amount is less than the "poverty line." Would not pressures then mount to continually raise the subsidy—especially during election years?

A PROPOSAL—GUARANTEED OPPORTUNITY

Just as it is unsound legislation to guarantee income as a matter of right—it is also unsound legislation to guarantee jobs as a matter of right. How can you guarantee a job to a person who does not want one? Once you guarantee a job you eliminate any need for a worker to demonstrate competence, the ability to learn, or the need for good work habits—e.g., habitual tardiness and absenteeism, vandalism could be expected.

But, you might argue, this situation would still be better than paying somebody for not working at all. The answer is you guarantee an opportunity to work. Then, if a person does not work, his (her) welfare check should be small enough to make him (her) very uncomfortable. This in turn would, I believe, make work opportunities seem very attractive indeed.

There is no one solution or one approach that will guarantee these opportunities, but the following guidelines should be followed.

1. The majority of the newly created jobs should be in the private sector.
2. Training should be done by private industry. Department of Labor training programs have been proven to be ineffective and it is not feasible for these programs to match up training with market place demands. In the American system that is the function of "free enterprise."
3. Government provided public service jobs can serve as a flywheel—but should provide only a small proportion of the newly created jobs.

Objective: The objective of a guaranteed opportunities program would be to provide everyone with an opportunity to perform useful work for a wage sufficient to provide for essential needs.

Gentlemen, I wish to pose a question.¹¹ If you were in charge of an underdeveloped country (e.g., the Mississippi Delta) where most of the people were undereducated and underfed, and you were given the opportunity to bring in 100 people to help your country, who would be the most valuable people you could bring in? Teachers? Doctors? Lawyers? Engineers? Perhaps social workers?

Probably none of these—no—100 entrepreneurs would contribute the most.

An entrepreneur is a person who organizes and manages an enterprise—a business—usually with considerable initiative and risk. He is an employer of productive labor. It is from this person that all else follows. The land is cleared, jobs are provided, schools and hospitals are built and staffed. Then all the other ingredients of a viable society follow. It is the entrepreneur—the self-starter—that must be put to work on this problem if we are to achieve our objective.

Profit and Loss Yardstick: The businessman—the entrepreneur—will not be put to work on this effort on the massive scale needed unless a way can be found for his efforts to be acceptable against the profit and loss yardstick. (This yardstick must be retained because the profit motive is responsible for America's success—relative to the rest of the world.)

American business and industry will not, at the present time, address itself to the problem on the massive scale required because of the many short-term dis-

¹¹ This is taken from an address by A. S. Farha before the International Luncheon Club, Midland, Mich., May 1971.

advantages connected with organizing and utilizing people who are not presently qualified for the world of work. These short-term disadvantages can be compensated for and overcome.

Some of the short-term disadvantages that must be overcome are:

1. High dropout rate.
2. Recurrent absenteeism.
3. The need to teach such basics as reading and arithmetic.
4. The difficulty of getting people that have never held a steady job to adjust to the 8-to-4 routine—adapt to discipline.
5. The need to train leaders who will make more mistakes than most while learning—and let these mistakes be made as a part of the learning process.
6. Higher level than normal of supervisors to workers.
7. High amount of scrap material because of lack of worker skill.
8. Lack of motivation.
9. Disadvantages of locating plants in underdeveloped parts of the country—e.g., Mississippi Delta.

Proposal—Tax concessions would be granted to labor intensive industries such as garments, textiles, and electronic parts assembly. To qualify a firm would hire a certain percentage of its workforce from the under-trained poor categories—the criteria established for the H.R. 1, O.F.F. Program could be used. The higher the percentage of the workforce in the O.F.F. category, the greater the tax concession that would be given.

This proposal would not displace presently employed workers because the persons hired from the O.F.F. categories would be hired to produce goods for a new market. That market is the poor who, prior to going to work, had no purchasing power to buy the goods and services that they are themselves now producing.

The tax concession program would be designed to encourage companies to build plants in economically depressed and underdeveloped parts of the country such as the Mississippi Delta and Appalachia. It would also encourage the location of small, light manufacturing plants in the core of the city (this would be a much more effective solution for the ghettos than existing renewal projects, which wipe out slum housing and erect high rise apartment and office buildings, but do not supply jobs for the residents).

To ensure that these new plants continue to operate—i.e., that the businessman does not pick up his marbles and leave after the tax holiday has been diminished—it might be necessary to require that a specified percentage of the profits be invested back into the area where the plant is located.

A hypothetical example showing how the tax break might diminish as short-term disadvantages are overcome is shown in exhibit 9.

The percentage of Federal income tax reduction would be in proportion to the added risk taken. It is assumed in this example that the effectiveness of a plant locating in an economically depressed area and employing under-trained workers would be 27% of that of a plant locating in a developed region. The underdeveloped area might be the Mississippi Delta or an urban slum. In this example comparative effectiveness increases to 100% at the end of 10 years and the 100% tax holiday provided for the first years drops off to "0."

Under this proposed amendment to H.R. 1, the tax concessions would supply the incentive for business to take the added risks necessary if the short-term disadvantages associated with the economically depressed regions and with putting the poor to work are to be overcome. The businessmen becomes involved in solving these problems as part of the day-to-day operations of his firm. This approach will guarantee overall success because it does not guarantee against failure of an individual firm. This risk of failure is a prerequisite to success. This legislation would let the businessman do what he does best—perform against the veritable yardstick of profit and loss. Planning would be done by tough minded managers who are judged only by results—not by insular bureaucratic agencies.

I don't pretend to suggest that this proposed tax scheme would be a cure-all. It can, however, bring into this battle what President Nixon has termed "the greatest engine of progress ever developed in the history of man—American private enterprise."

Demonstrated Success—The tax incentive is not a new concept. Many states have tax holiday programs. Likewise with local communities. On the federal level, a familiar tax incentive to spur general growth in the economy is the investment credit.

The Commonwealth of Puerto Rico presents a highly successful example of the type of program that I am proposing.

EFFECT OF TAX VACATION

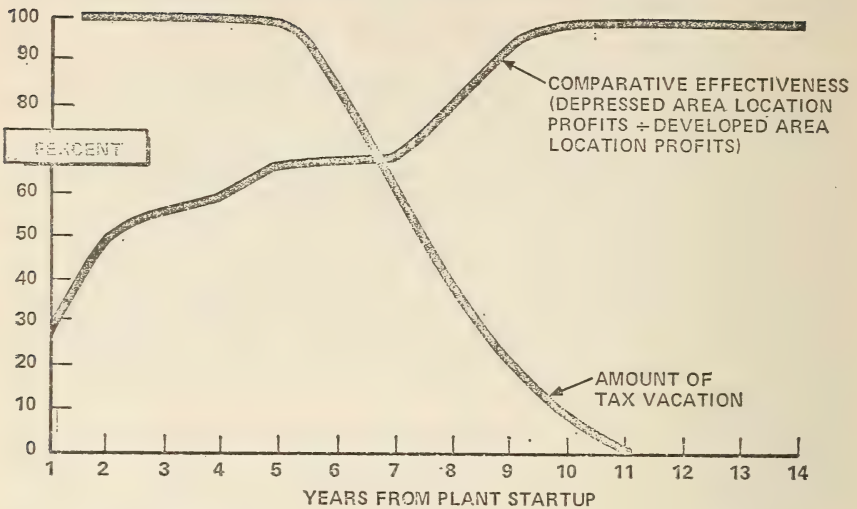


Exhibit 9

One way of measuring economic progress is by the growth in real per capita income. Exhibit 10 compares the relative growth in real per capita income of Puerto Rico to that of the United States and Mississippi along with Latin America and Uruguay. Uruguay is again shown to depict the stark contrast in results between a country like Uruguay that tried to eradicate poverty through government welfare and Puerto Rico that adapted another approach—that of improving the productivity of her people by encouraging entrepreneurship.

Much of this prodigious growth has been attributed to a tax holiday package that was legislated in 1947. Under this program, qualifying industries are exempted from all corporate income tax for varying periods of time, depending on type of industry and location. The Puerto Rican government's recent extension until 1983 of the tax holiday scheme will undoubtedly encourage continued progress.

I am not suggesting that Puerto Rico doesn't have its problems. It does.

Last year's unemployment rate of about 10.5%, which some observers place much higher, would have been more severe if it had not been for migration to the U.S. mainland. There is also a serious shortage of skilled labor. Per capita income is still only about 70% of that of Mississippi. But take note—Puerto Rico is catching up fast. If trends continue, it will exceed that of Mississippi within the decade, as shown in exhibit 11.

I have outlined the Puerto Rican experience to show the general results that can be expected—not as a model of the tax incentive program that is proposed to generate new jobs in the States. The major difference is that the tax holiday legislation that I have recommended would be designed to encourage labor intensive industries. Puerto Rico's tax holiday is based on a long-standing government policy of promoting growth in capital intensive highly automated industries such as petrochemicals. This policy is thought to be partly responsible for the island's unemployment crunch and skilled labor shortage.

Despite these problems, I think that most observers would agree that Puerto Rico's economic progress has been fantastic.

Puerto Rico accomplished this against a backdrop of considerable obstacles. Manufacturing plants in the early fifties were essentially non-existent and the economy was heavily dependent on agriculture—mostly sugar. Population pressures are severe. Puerto Rico is six times more densely populated than the state of California and has a population density 2,000% greater than that enjoyed by Uruguay. As for natural resources, the island is blessed with very few.

Puerto Rico's Economic Development Administration predicts that 225,000

jobs will have been created by the end of the decade as a direct result of the incentive package. In proportion to population, this would be equivalent to 16 million new jobs in the U.S. mainland.

INCREASE IN REAL PER CAPITA INCOME
CONSTANT 1958 \$'s
(1950 - 1969)

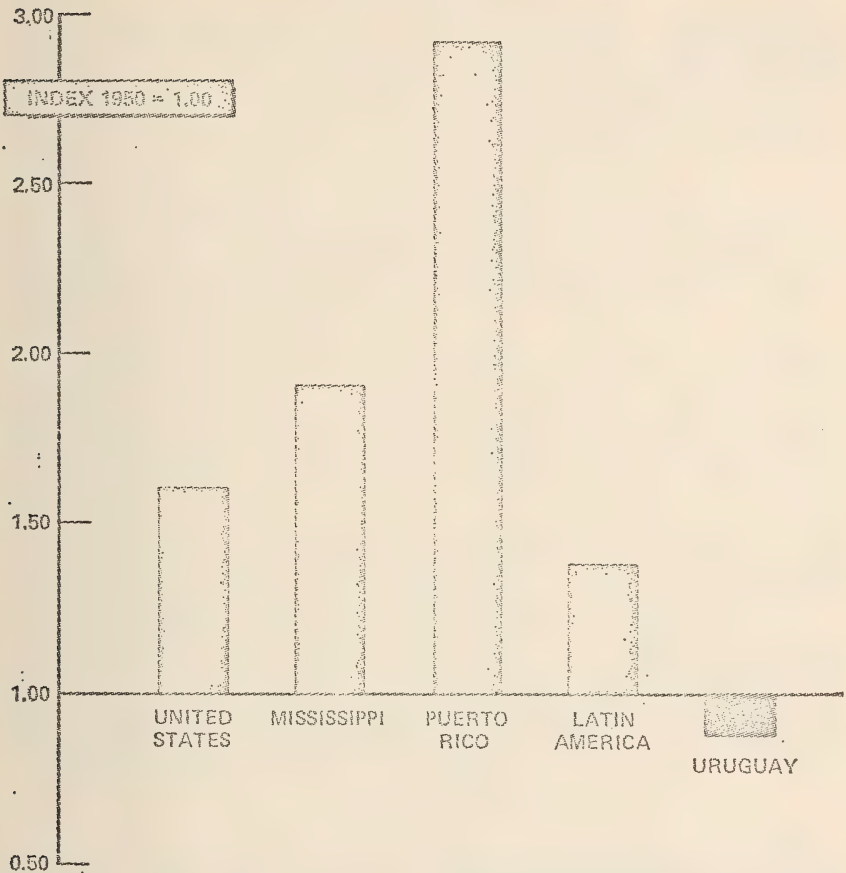


Exhibit 10

Public Service Jobs—If we are to have a “Guaranteed Opportunities” program, it will be necessary for government to become the “employer of last resort.” There is an increasing need for public service jobs and swings in the jobs available in the private sector are bound to continue. Many of these public service jobs can be of a project nature and the public service sector can act as sort of a flywheel to dampen out the wide swings in unemployment. I think that more effort must be devoted to identifying the specific jobs that government would create. These jobs could probably include ecology efforts such as the recycling of man-made wastes, work in parks, in hospitals, and a limited number of jobs on public works projects.

One way of providing needed jobs, while at the same time contributing to a better environment, would be through the formation of a joint government-private ecological corporation. This corporation could be similar in structure to Comsat Corporation. It would recycle man-made waste material (paper, glass) that would be unattractive to recycle on the basis of pure economics.

COMPARISON OF PER CAPITA INCOMES
 PUERTO RICO PER CAPITA INCOME \div MISSISSIPPI PER CAPITA INCOME

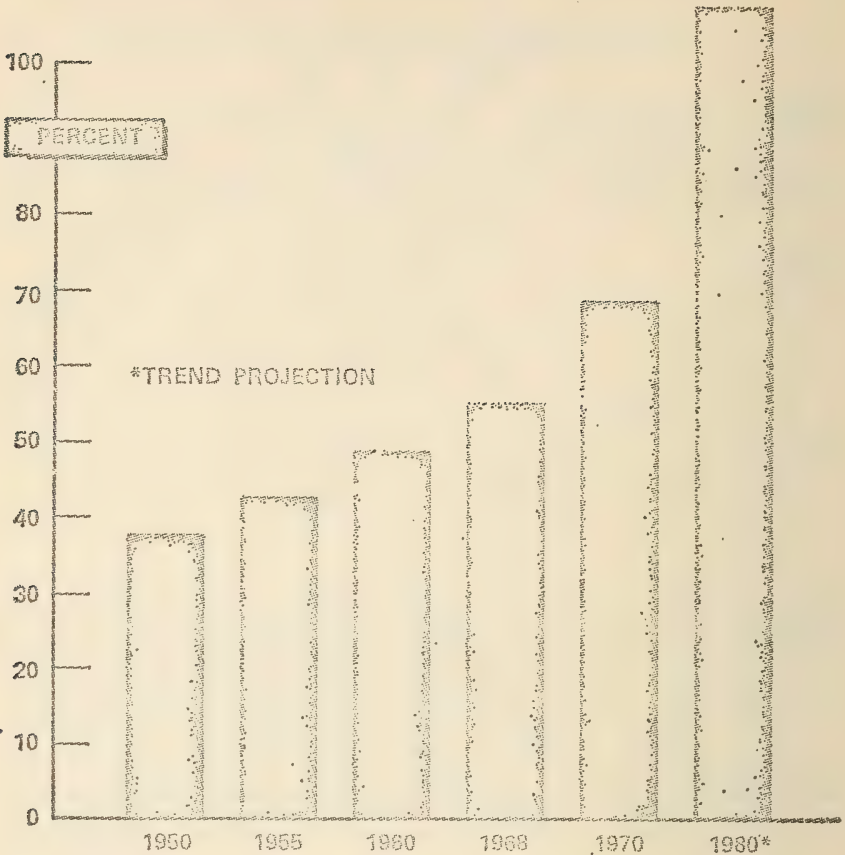


Exhibit 11

If we are to guarantee opportunity it is imperative that these "last resort" government created jobs be transitional. They should provide the worker with an opportunity to advance into permanent jobs in regular employment.

The language in the recently passed Emergency Employment Act could supply the mechanism to turn on and off the availability of these jobs. As I understand it, federal spending is turned on when unemployment goes above a given percentage for a specified number of months in a row and is turned off when unemployment dips below the given percentage for the specified length of time.

Chairman Mills has stated that the purpose of the public service jobs provision [in H.R. 1] is to see that those people who do not find work in regular employment may have an opportunity to get work in these [public service] projects.

The key here is regular employment. As regular employment becomes more plentiful to the under-trained through the proposed tax incentive program the need for "government as the employer of last resort" will diminish.

With guaranteed opportunity, the need for welfare benefits of anything more than bareboned subsistence will diminish. Welfare payments under current law should then be programmed to be cut back accordingly for able-bodied recipients.

APPENDIX

COMPETITION BETWEEN WELFARE ROLLS AND PAYROLLS—ANALYTICAL BACKUP MATERIAL FOR AN ANALYSIS OF THE ADMINISTRATION'S FAMILY ASSISTANCE PLAN (H.R. 1), 1971, DELTA ASSOCIATES

(By William H. Shaker)

The purpose of the Job Sensitivity Charts (Exhibits 4-7) is to present the overall impact of guaranteed income legislation in an easily understood format. These charts show jobs, by state, that would be affected by the various guaranteed income proposals. Since these charts are intended as an overview, they do not necessarily show all jobs in a particular state that might be affected by a given guaranteed income proposal. More detailed information is contained in the attached Tables.

Data availability dictated that certain estimates and assumptions be made and the basis for this is given in Tables I-VI, along with the data sources.

Table I shows the approximate income floor under H.R. 1 that would exist in the various states—assuming that state supplements continue at present levels. Also contained in Table I is the manufacturing pay rate as a percentage of the U.S. average manufacturing pay rate for each state.

Table II shows jobs in the manufacturing sector affected by the various guaranteed income plans.

Table III presents national pay rates for selected jobs in other than the Manufacturing Sector of the economy. These rates are based on testimony submitted by Secretary James D. Hodgson to the Committee on Finance, United States Senate during Administration testimony on H.R. 1. Estimates of pay rates in the individual states were derived by multiplying the rates submitted by Secretary Hodgson by the percentages reported in Table I. This procedure was necessary because pay rates for these jobs were not available on a state-by-state basis.

In general, the analysis is based on gross earnings. This procedure underestimates the impact of the guaranteed income plans because welfare recipients do not pay Federal social security and income taxes on their welfare payments. An exception to this procedure was made in the case of the Javits Amendment. In that instance, an estimate of spendable earnings was used. See Table IV.

Negative income tax proposals are promoted as a means of supplementing the incomes of the "working Poor". H.R. 1 would also supplement the earnings of persons in the middle income brackets. Table V shows the average hourly earnings that a person could receive and still get some welfare payment. As can be seen in Table V, the average hourly earnings in 10 states is less than the amount of earnings required for a person to "work himself off welfare".

Table VI presents an estimate of the number of jobs that would be affected by the Javits' Amendment in a few selected states.

TABLE I

State	Approximate income floor under H.R. 1 (basic Federal \$2,400. Plus State supplements at present levels)	Manufacturing pay rate as a percentage of U.S. average pay rate
	(1)	(2)
Alabama.....	\$1.20	86
Alaska.....	2.25	146
Arizona.....	1.20	102
Arkansas.....	1.20	79
California.....	1.32	117
Colorado.....	1.59	107
Connecticut.....	1.98	104
Delaware.....	1.20	107
District of Columbia.....	1.43	108
Florida.....	1.20	86
Georgia.....	1.20	80
Hawaii.....	1.58	95
Idaho.....	1.45	101
Illinois.....	1.69	110

TABLE I—Continued

State	Approximate income floor under H.R. 1 (basic Federal \$2,400. Plus State supple- ments at present levels)	Manufacturing pay rate as a percentage of U.S. average pay rate
	(1)	(2)
Indiana.....	1.20	113
Iowa.....	1.46	109
Kansas.....	1.64	100
Kentucky.....	1.20	98
Louisiana.....	1.20	99
Maine.....	1.20	82
Maryland.....	1.20	102
Massachusetts.....	1.88	97
Michigan.....	1.58	132
Minnesota.....	1.79	106
Mississippi.....	1.20	76
Missouri.....	1.20	103
Montana.....	1.37	111
Nebraska.....	1.20	95
Nevada.....	1.20	130
New Hampshire.....	1.76	83
New Jersey.....	2.08	105
New Mexico.....	1.20	86
New York.....	2.02	104
North Carolina.....	1.20	74
North Dakota.....	1.57	91
Ohio.....	1.20	116
Oklahoma.....	1.20	95
Oregon.....	1.35	114
Pennsylvania.....	1.88	101
Rhode Island.....	1.58	86
South Carolina.....	1.20	76
South Dakota.....	1.80	91
Tennessee.....	1.20	83
Texas.....	1.20	98
Utah.....	1.27	107
Vermont.....	1.82	88
Virginia.....	1.57	83
Washington.....	1.82	121
West Virginia.....	1.20	103
Wisconsin.....	1.30	108
Wyoming.....	1.36	104

¹ Derived from data furnished in table 9, p. 55, app. B—material related to H.R. 1—work and training provisions (prepared by the staff of the Committee on Finance)—published in hearings before the Committee on Finance, U.S. Senate, 92d Cong.—1st sess. on H.R. 1, p. 393. U.S. Government Printing Office, 1971.

Derivation is based on the lower figure shown in table 9 for each State and does not assume a family member in training. For example: Alabama $((\$230 - \$30) \times 12) \div 2,000 = \1.20 ; Iowa $((\$274 - \$30) \times 12) \div 2,000 = \1.46 , etc.

² Derived from detailed State statistics published in "Employment and Earnings State and Area Earnings", U.S. Department of Labor, BLS, Bulletin No. 1370. U.S. Government Printing Office.

Manufacturing pay rate as a percentage of U.S. average pay rate was developed as follows:

$$\text{National average} = \frac{\text{average hourly earnings (State}_1 + \text{State}_2 + \dots + \text{State}_{50} + \text{D.C.})}{51} = \$2.97,$$

$$\text{State}(i) (\text{percent}) = \frac{\text{State}_i \times 100}{\$2.97}$$

For example: Alabama $(2.55/2.97) \times 100 = 86$ percent.

TABLE H.—SENSITIVITY OF JOBS IN THE MANUFACTURING SECTOR OF ECONOMY TO GUARANTEED INCOME PLANS, BY STATE¹

State	H.R. 1 (\$2,400 plus State supplements)	Poverty level (\$4,116)	Senator Javits' amendment (\$4,800)	N.W.R.O. demand (\$6,500)
Alabama	Apparel	Fab. metals, apparel, food and kindred products, weaving mills.		Fabricated metals (\$2.62), transp. equip. (\$3.03), apparel (\$1.70) food and kindred prod. (\$2.16), textile mill products (\$2.13), print'g and publish'g (\$3.02), weaving mills (\$2.17), chemicals and allied (\$2.83), mining (\$3.21).
Alaska				
Arizona				
Arkansas	Food products, apparel, wood products, furn. and fixtures.	Food products, apparel, wood products, furniture and fixtures, primary metal indus., fab. metal products, machinery, elec. equipment and suppl., print'g and publish'g.		Machinery (\$2.75), food and kindred (\$2.80). Food products (\$2.03), apparel (\$1.93), wood products (\$2.09), furniture and fixtures (\$2.03), primary metal indus. (\$2.73), fab. metal products (\$2.28), machinery (\$2.28), elec. equipment and supplies (\$2.13), Print'g and publish'g (\$2.16), Chem. and chem. prod. (\$2.90).
California	Apparel	Apparel, toys and sporting gds.		Wood containers (\$2.97), furniture and fixtures (\$3.04), pottery and related prod. (\$2.73), iron and steel found. (\$3.17), non-ferrous found. (\$3.08), plumbing and heat'g (\$3.99), elec. light'g and wir'g (\$2.74), elec. compon. and acces. (\$2.93), mech. meas. and control (\$3.05), textile mill products (\$2.54), drugs (\$2.95), rubber and plastics prod. (\$2.71), leather products (\$2.33), toys and sport'g goods (\$2.48), canned and froz. sea-food (\$2.66), apparel (\$2.03). Machinery (\$3.21).
Colorado				
Connecticut	Apparel	Apparel		Fab. metal products (\$2.88), elec. equip. and suppl. (\$2.79), instru. and related prod. (\$2.71), jewelry, silverware (\$3.12), nonmetallic mfg. (\$2.89), food and kindred products (\$2.98), apparel and textile prod. (\$2.21), lumber and furn. prod. (\$2.69), paper and allied prod. (\$2.99), rubber and plastic prod. (\$3.12). Food and kindred prod. (\$2.28), textile mill products (\$2.46), apparel (\$2.10), rubber and plastic prod. (\$2.94), leather and leather prod. (\$2.87).
Delaware	Apparel, food products, textile mill products.			Food products (\$3.04), durable goods (\$2.99). Durable goods (\$2.61), nonmetallic minerals (\$2.75), phosphate rock (\$2.94), food products (\$2.46), apparel (\$2.09), wood products (\$2.22), furn. and fixtures (\$2.26), stone, clay, glass prod. (\$2.47), primary metal indus. (\$2.51), fab. metal products (\$2.55), machinery (\$2.67), electrical equipment (\$2.84), transportation equip. (\$3.01), instruments, related (\$2.34), ordinance (\$2.83), nondurable mfg. (\$2.49), canned, froz. foo.s (\$1.99), tobacco mfg. (\$1.98), pri t'g and publish'g (\$3.05), chemicals, allied prod. (\$2.81), communications (\$2.86).
District of Columbia				Lumber and wood prod. (\$1.90), furniture, fixtures (\$2.15), stone, glass, clay prod. (\$2.39), primary metal prod. (\$2.47), fab. metal products (\$2.50), machinery (\$2.58), elec. equip. and suppl. (\$2.81), nondurable goods (\$2.44), food, kindred prod. (\$2.42), textile mill prod. (\$2.13), weaving mills (\$2.16), knitting mills (\$1.99), tufted carpets rugs (\$2.05), yarn, thread mills (\$2.10), apparel (\$1.96), paper, allied products (\$3.11), chemicals, allied prod. (\$2.54), leather and leather prod. (\$1.94).
Florida	Apparel, canned, froz. fids., tobacco mfg.	Apparel, canned, froz. foods, tobacco mfg., furniture, lumber, wood prod.		
Georgia	Apparel, knitting mills, leather products, lumber, wood prod.	Apparel, knitting mills, food products, furniture, fixtures, instruments, leather, leather prod., lumber, wood products, textile mills, stone, clay, glass, weaving mills, yarn mills.		

TABLE H.—SENSITIVITY OF JOBS IN THE MANUFACTURING SECTOR OF ECONOMY TO GUARANTEED INCOME PLANS, BY STATE I—Continued

State	H.R. 1 (\$2,400 plus State supplements)	Poverty level (\$4,116)	Senator Javits' amendment (\$4,800)	N.W.R.O. demand (\$6,500)
Hawaii	Apparel	Apparel	Apparel, textile mills, food, kindred products	Food, kindred prod. (\$2.59), textiles, apparel (\$1.94).
Idaho			Food products	Food Products (\$2.44), Communications (\$2.86)
Illinois			Apparel, Electr. components, knitting mills, textile mills.	Ordinance (\$3.02), lumber, wood prod. (\$2.65), furniture, fixtures (\$2.95), household furn. (\$2.77), cement, stru. clay, pottery (\$3.07), cutlery, hand tools, etc. (\$3.12), plumbing, heating (\$2.90), metal saws (\$2.88), office, computing mach. (\$2.87), elec. equip., suppl. (\$2.85), radio, T.V. receiv g eq. (\$2.60), electronic components (\$2.43), instruments (\$3.07), canned, froz. foods (\$2.63), bakery products (\$3.15), confection, related prod. (\$2.77), textile mill products (\$2.21), apparel (\$2.25), drugs (\$2.97), rubber, plas. prod. (\$3.00), rubber products (\$3.05), leather, leather prod. (\$2.51), footwear (\$2.21).
Indiana	Apparel, Canned, froz. foods	Apparel, Canned, froz. foods	Apparel, canned, froz. foods, leather products, textile mill products.	Lumber, wood prod. (\$2.30), furniture, fixtures (\$2.60), stone, clay, glass prod. (\$3.09), radio, T.V., communicat. (\$2.87), electronic components (\$2.87), instruments, related (\$2.75), ordinance (\$3.09), food, kindred products (2.96), canned, froz. foods (\$2.11), textiles, apparel (\$2.11), paper products (\$2.98), rubber, plastic products (\$2.97).
Iowa	Apparel, textile mills	Apparel, textile mills	Apparel, textile mills	Nonmetallic metals (\$2.77), lumber, furniture (\$2.49), stone, clay, glass prod. (\$2.95), fab. metal prod. (\$2.98), electric equip. suppl. (\$2.83), transportation equip. (\$2.76), apparel, textiles (\$2.08).
Kansas	Apparel, primary metal, textile mills.	Apparel, primary metal, textile mills.	Apparel, primary metal, textile mills.	Oil and gas extraction (\$2.92), stone, clay, glass prod. (\$2.95), primary metal industries (\$2.32), fab. metal products (\$2.72), machinery (\$2.69), transportation equip. (\$3.21), food, kindred products (\$2.90), dairy products (\$2.40), grain and mill products (\$2.68), apparel, textile mills (\$1.81), printing and publishing (\$2.93), trucking and warehousing (\$3.21), mining (\$2.93).
Kentucky	Apparel, textile mills, tobacco mfg.	Apparel, textile mills, tobacco mfg.	Apparel, furniture, leather products, textile mills, tobacco mfg.	Food products (\$3.00), apparel (\$1.96-\$2.10), wood products (\$2.49-\$2.61), paper (\$2.48-\$2.72), furniture, fixtures (\$2.22), stone, clay, glass prod. (\$2.89), fab. metal products (\$2.89), electrical equip. suppl. (\$3.05), food, kindred products (\$2.95), tobacco mfg. (\$2.86), textile mill products (\$1.95), paints, allied products (\$2.92), petroleum, rubber, plas. prod. (\$2.73), leather and leather prod. (\$2.08).
Louisiana	Apparel, furniture, leather products.	Apparel, furniture, leather products.	Apparel, food products, furniture, lumber, wood prod., leather products.	Food products (\$2.38-\$2.55), apparel (\$1.88-\$1.96), wood products (\$1.89-\$2.08), fab. metal products (\$3.02), machinery (\$3.07), transportation equip. (\$3.10), furniture (\$1.88).
Maine	Apparel	Apparel	Apparel, food products, leather products, lumber, wood products, metal working industries, primary metal, textile mills.	Lumber, wood products (\$2.34), primary metal prod. (\$2.43), metal working indus. (\$2.43), food products (\$2.13), textile mill products (\$2.13), apparel (\$1.97), leather, leather products (\$2.20).

Maryland	Leather products	Apparel, leather products, textile mills	Electrical equip., suppl. (\$2.92), food products (\$2.59), textile mill products (\$2.15), paper products (\$2.62), apparel (\$2.21), chem., allied prod. (\$3.01), leather, leather prod. (\$2.03).
Massachusetts		Apparel, leather products, textile mill products	Ordinance (\$2.89), lumber, wood prod. (\$2.63), furniture, fixtures (\$2.53), fab. metal products (\$2.91), electrical equip. & suppl. (\$2.79), instruments, related (\$2.99), food products (\$2.74), textile mill products (\$2.38), apparel (\$2.28), rubber, plastic prod. (\$2.80), leather, leather prod. (\$2.46).
Michigan			Paper products (\$3.30), leather products (\$2.51), wood products (\$2.58), furniture (\$2.96).
Minnesota	Apparel	Apparel, textile mills	Lumber, wood prod. (\$2.81), furniture (\$2.91), stone, clay, glass prod. (\$3.03), textile mill prod. (\$2.34), apparel and textiles (\$2.05), chemicals, petroleum (\$3.11).
Mississippi	Apparel, food products, furniture, knitting mills, lumber, wood prod., textile mills, saw mills	Apparel, fab. metal prod., food products, furniture, knitting mills, lumber, wood prod., machinery, print'g, publish'g, primary metal, textile mills, stone, clay, glass, saw mills.	Food products (\$1.98-\$2.07), apparel (\$1.82-\$1.87), wood products (\$2.02-\$2.12), furniture (\$2.06), stone, clay, glass prod. (\$2.17), primary metals (\$2.37), fab. metal products (\$2.37), machinery (\$2.39), textile mill products (\$2.07), print'g, publish'g (\$2.46), chemicals, allied prod. (\$2.54), saw mills (\$2.26).
Missouri	Apparel, leather, leath. prod., lumber, wood prod.	Apparel, leather, leather prod., lumber, wood prod., textile mill products.	Apparel (\$2.05-\$2.14), paper (\$2.73-\$2.89), wood products (\$2.07-\$2.16), leather products (\$2.07-\$2.39), furniture (\$2.54), stone, clay, glass prod. (\$3.16), elect. equip. and suppl. (\$2.89), instruments, related (\$2.83), textile mill products (\$2.13).
Montana			Primary metal indust. (\$3.21), food products (\$3.01), communications (\$3.19), elec., gas, sanitat. serv. (\$3.19).
Nebraska			Lumber (\$2.50), stone, clay, glass prod. (\$2.50), primary, metals (\$2.76), fab. metals (\$2.76), machinery (\$2.74), transporta. equip. (\$2.74), food products (\$3.00), dairy products (\$2.71), grain mill products (\$2.69), baking products (\$2.59), chem., allied prod. (\$2.59).
Nevada			Printing and publishing (\$3.00).
New Hampshire	Apparel	Apparel, elec. equip. suppl., furniture, leather products, lumber, wood prod., textile mill products.	Lumber and wood prod. (\$2.23), furniture (\$2.31), primary metal (\$2.54), fab. metal prod. (\$2.58), elec. equip., suppl. (\$2.43), food products (\$2.68), textile mill products (\$2.24), apparel (\$2.05), paper and products (\$2.74), print'g and publish'g (\$2.91), leather, leather prod. (\$2.30), footwear (\$2.28).
New Jersey		Apparel, leather products, serv. indus. machines	Lumber, wood prod. (\$2.54), furniture (\$2.62), canned, froz. foods (\$2.81), electronic components (\$2.35), glass (\$3.04), grain and mill products (\$2.88), pottery (\$2.78), tobacco mig. (\$2.67), rubber, plastics prod. (\$3.04), metal work g. (\$3.02), textile mill products (\$2.75), leather, leather prod. (\$2.34), serv. industry machines (\$2.47), weaving mills (\$2.56), elec. equip., supplies (\$2.97), apparel (\$2.24), elec. test and distrib. equip. (\$3.01), paper and products (\$2.98), electri. indus., apparatus (\$2.98), elec. light g. wir. g. (\$2.72), radio, T.V., receiv. g. eq. (\$2.67), communications (\$3.08), gas and electric (\$3.08), sanitation services (\$3.08), food products (\$2.11), furniture (\$2.08).
New Mexico	Food products, furniture, lumber, wood prod.	Food products, furniture, lumber, wood products	

TABLE H—SENSITIVITY OF JOBS IN THE MANUFACTURING SECTOR OF ECONOMY TO GUARANTEED INCOME PLANS, BY STATE I—Continued

State	H.R. 1 (\$2,400 plus State supplements)	Poverty level (\$4,116)	Senator Javits' amendment (\$4,800)	N.W.R.O. demand (\$6,500)
New York	Poultry dressing plants.	Toys, sport'g gds, canned froz. foods.	Apparel, canned, froz. foods, confection. foods, household appl., leather products, lumber, wood prod., toys, sporting goods, weaving mills, electronic components, furniture, fixtures, paper products, rubber, plastic products, metal services, textiles, elec. wir'g, light'g radio, TV receiv'g, equip.	Toys, sport'g goods (\$2.11), lumber, wood prod. (\$2.43), weaving mills (\$2.73), furniture, fixtures (\$2.71), paper products (\$2.69), rubber, plastics prod. (\$2.57), nonmetallic miner. prod. (\$2.97), soaps (\$2.90), leather products (\$2.15), lab. metal prod. (\$3.13), cutlery, hand tools (\$2.83), drugs (\$3.05), plumb'g, heat'g (\$2.98), electronic components (\$2.59), metal services (\$2.55), mechanical meas., contro. (\$3.03), gen. industr. machinery (\$3.19), medical instruments (\$2.87), elec. equip., supplies (\$2.83), ophthalmic goods (\$2.90), household appl. (\$2.42), food products (\$3.03), textiles (\$2.58), elect. wir'g, light'g, Eq. (\$2.70), canned, frozen foods (\$2.28), radio, TV receiv'g, equip. (\$2.70), confectionery prod. (\$2.41), silver ware (\$2.93), communications equip. (\$3.05), apparel (\$2.29), jewelry (\$2.98), poultry dressing plants (\$2.00).
North Carolina	Apparel, beverages, food products, furniture, grain mill products, lumber, wood prod., textile mills, tobacco mfg., saw mills, paper products, trans. equipment, stone, clay, glass prod., weaving mills, mining, com., gas, elec., sanitation services, primary metal, lab. metal products, machinery, plastics and synthetics, elec. equip., supplies, meat products, dairy products, bakery products, print'g and publish'g, chemical and allied prod.	Apparel, beverages, food products, furniture, grain mill products, lumber, wood prod., textile mills, tobacco mfg., saw mills, paper products, trans. equipment, stone, clay, glass prod., weaving mills, mining, com., gas, elec., sanitation services, primary metal, lab. metal products, machinery, plastics and synthetics, elec. equip., supplies, meat products, dairy products, bakery products, print'g and publish'g, chemical and allied prod.	Apparel, beverages, food products, furniture, grain mill products, lumber, wood prod., textile mills, tobacco mfg., saw mills, paper products, trans. equipment, stone, clay, glass prod., weaving mills, mining, com., gas, elec., sanitation services, primary metal, lab. metal products, machinery, plastics and synthetics, elec. equip., supplies (\$2.41), trans. portal, equip. (\$2.46), meat products (\$1.92), dairy products (\$2.14), grain mill products (\$2.03), bakery products (\$2.19), mining (\$2.34), beverages (\$1.88), tobacco mfg. (\$2.67), cigarette mfg. (\$2.97), tobacco steaming, dry'g (\$1.93), weaving (\$2.21), paper products (\$2.35), printing and publish'g (\$2.73), chemicals and allied prod. (\$2.67).	Lumber, wood prod. (\$1.99 \$2.09), food products (\$2.00 \$2.14), apparel (\$3.90), wood products (\$2.09), paper (\$3.11), communications, gas, elec. (\$2.75), sanitation services (\$2.75), saw mills (\$1.91), furniture (\$2.03), stone, clay, glass (\$2.18), primary metal (\$2.74), lab. metal prod. (\$2.56), machinery (\$2.45), plastics and synth. (\$2.67), elec. equip., supplies (\$2.41), trans. portal, equip. (\$2.46), meat products (\$1.92), dairy products (\$2.14), grain mill products (\$2.03), bakery products (\$2.19), mining (\$2.34), beverages (\$1.88), tobacco mfg. (\$2.67), cigarette mfg. (\$2.97), tobacco steaming, dry'g (\$1.93), weaving (\$2.21), paper products (\$2.35), printing and publish'g (\$2.73), chemicals and allied prod. (\$2.67).
Oregon	Apparel, textile mills.	Apparel, canned, froz. foods, textile mills.	Apparel, canned, froz. foods, textile mills.	Furniture, fixtures (\$2.72), food, kindred prod. (\$2.94), canned, frozen foods (\$2.45), apparel (\$2.06), textile mills (\$2.06).
Pennsylvania	Tobacco mfg., knitting mills, leather products.	Lumber, wood products, furniture, cutlery, handtools, elec. light'g, wir'g equip., electronic components, canned, froz. foods, confectionary products, tobacco mfg., textiles, weaving mills, apparel, leather products.	Lumber, wood prod. (\$2.42), furniture (\$2.82), stone, clay, glass prod. (\$3.01), glass and glassware (\$2.86), pottery (\$2.85), concrete, gyss, plaster prod. (\$2.80), grey iron foundries (\$2.98), cutlery, handtools (\$2.59), plumb'g, heat'g (\$2.99), lab. wire products (\$2.89), lab. metal products (\$3.06), service industry mach. (\$2.98), electric, equip. supplies (\$3.06), electrical indus. apparel. (\$2.88), household appliances (\$3.13), elec. light'g, wiring (\$2.65), radio, TV, commu. equip. (\$2.77), electronic components (\$2.66), instruments (\$2.87), food products (\$2.80), meat products (\$2.99), dairy products (\$2.86), canned, froz. foods (\$2.46), bakery products (\$2.86), confectionary prod. (\$2.46), tobacco mfg. (\$2.03), textile (\$2.24), weaving (\$2.26), knitting mills (\$2.02), apparel (\$2.21), paper products (\$2.80), chemicals, allied prod. (\$3.07), plastic (\$3.13), drugs (\$3.13), paints (\$3.21), rubber products (\$2.92), leather products (\$2.09), communications (\$3.10).	Furniture, fixtures (\$2.72), food, kindred prod. (\$2.94), canned, frozen foods (\$2.45), apparel (\$2.06), textile mills (\$2.06). Lumber, wood prod. (\$2.42), furniture (\$2.82), stone, clay, glass prod. (\$3.01), glass and glassware (\$2.86), pottery (\$2.85), concrete, gyss, plaster prod. (\$2.80), grey iron foundries (\$2.98), cutlery, handtools (\$2.59), plumb'g, heat'g (\$2.99), lab. wire products (\$2.89), lab. metal products (\$3.06), service industry mach. (\$2.98), electric, equip. supplies (\$3.06), electrical indus. apparel. (\$2.88), household appliances (\$3.13), elec. light'g, wiring (\$2.65), radio, TV, commu. equip. (\$2.77), electronic components (\$2.66), instruments (\$2.87), food products (\$2.80), meat products (\$2.99), dairy products (\$2.86), canned, froz. foods (\$2.46), bakery products (\$2.86), confectionary prod. (\$2.46), tobacco mfg. (\$2.03), textile (\$2.24), weaving (\$2.26), knitting mills (\$2.02), apparel (\$2.21), paper products (\$2.80), chemicals, allied prod. (\$3.07), plastic (\$3.13), drugs (\$3.13), paints (\$3.21), rubber products (\$2.92), leather products (\$2.09), communications (\$3.10).

Rhode Island	Apparel	Stone, clay, glass prod., prim. metal industries, fab. metal products, elec. equip. and suppl., food, textiles, apparel, rubber products, jewelry.
South Carolina	Food products, apparel, wood products, furniture, stone, clay, glass, fab. metal prod., machinery, elec. equip., suppl., instruments, beverages, textiles mills, weaving, yarn, thread mills.	Food products (\$2.05), apparel (\$1.82-\$1.90), wood products (\$1.90-\$2.03), furniture (\$1.92), stone, clay, glass (\$2.45), fab. metal products (\$2.21), machinery (\$2.29), elec. equip., supplies (\$2.00), instruments (\$2.13), beverages (\$1.79), textile mills (\$2.21), weaving mills (\$2.21), yarn and thread mills (\$2.04), print'g and publishing (\$3.07), chemicals (\$2.99).
South Dakota	Lumber, wood products, fab. metal products, machinery, trans. equipment.	Lumber, wood products (\$2.28), fab. metal products (\$2.30), machinery (\$2.30), transportation equip. (\$2.30) food products (\$2.90), paper products (\$2.84), print'g, publishing (\$2.84), transp., public utilities (\$3.15), communications (\$2.98), electric and gas (\$2.98), sanitary services (\$2.98).
Tennessee	Apparel, lumber, wood prod., furniture, tobacco mfg., textiles, knitting mills, yarn, thread mills.	Food products (\$2.43), apparel (\$2.05), paper (\$3.11), lumber, wood products (\$1.97), furniture (\$1.91), chemicals (\$3.13), rubber, plastic products (\$3.01), leather, leather prod. (\$2.14), stone, clay products (\$2.86), fab. metal products (\$2.74), machinery (\$2.44), elec. equip. (\$2.50), trans. equip. (\$2.75), ordinance (\$2.49), tobacco (\$2.05), textiles (\$2.03), knitting mills (\$1.97) yarn, thread mills (\$2), paper, paper products (\$2.96).
Texas	Apparel, wood products, leather products, textile mills.	Food products (\$2.44-2.56), apparel (\$1.91-\$1.95), wood prod. (\$2.02-\$2.17), paper products (\$3-\$3.15), leather products (\$1.81-\$2.03), furniture (\$2.22), stone, clay, glass (\$2.50), fab. metal products (\$2.88), machinery (\$2.94), elec. equip. and supplies (\$2.78), textiles (\$2.02), printing and publishing (\$3.08) communications (\$3.05), elec. gas, sanitary serv. (\$3.05).
Utah	Lumber, wood prod, apparel	Fabricated metals (\$3.20), food products (\$2.88), ordinance (\$3.13), Lumber, wood products (\$2.15), furniture (\$2.30), stone, clay, glass (\$2.74), machinery (\$2.96) elec. equip., supplies (\$2.79), food products (\$2.08), textile mills (\$2.24), apparel (\$1.82), paper products (\$2.60), print'g and publishing (\$2.76).
Vermont	Apparel	Furniture, fixtures (\$1.99), elec. equipment (\$2.40), stone, clay, glass (\$2.35), knitting mills (\$1.92), cigarets (\$2.99), pot. metal industries (\$2.48), weaving mills (\$2.22), apparel (\$1.88), machinery (\$2.71), food products (\$2.10), printing (\$2.93).
Virginia	Furniture, fixtur., knitting mills, apparel.	Furniture (\$3.01), elec. equip., supplies (\$2.88), food products (\$3.19), canned, froz. foods (\$2.60).
Washington	Canned, froz. foods.	Food (\$2.20-\$2.33), apparel (\$1.91-\$2.00), stone, clay, glass (\$2.91), pottery (\$2.41), fab. metal (\$2.82), machinery (\$2.82), elec. equip., supplies (\$2.94), printing and publishing (\$2.94), leather, leather prod. (\$2.04).
West Virginia	Apparel, leather, products.	Lumber, wood products (\$2.32), furniture, fixtures (\$2.60), fab. metal products (\$3.11), elec. equip. and supplies (\$3.13), instruments, related (\$2.94), food products (\$3.10), textile mills (\$2.06), apparel (\$2.06), chemicals, allied (\$3.21), rubber, plastics prod. (\$2.96), bath' and leather prod. (\$2.46).
Wisconsin	Textile mills, apparel	Food products (\$2.51).
Wyoming	Food products.	

¹ Derived from detailed State statistics published in "Employment and Earnings State and Area Earnings," U.S. Department of Labor, Bureau of Labor Statistics, Bulletin No. 1370-6, U.S. Government Printing Office. In some cases, earnings are based on supplemental data furnished by the individual States.

TABLE III

Pay rates for selected jobs in other than manufacturing sector of economy¹

Job	Hourly rate	Job	Hourly rate
Bank clerk.....	\$1. 75	Insurance agents.....	\$2. 45
Beautician.....	1. 63	Laundry.....	1. 67
Cook.....	2. 02	Nurses aid.....	2. 01
Dental assistant.....	1. 88	Office machine operator.....	2. 30
Deliveryman.....	2. 50	Receptionist.....	2. 25
Domestics.....	1. 83	Retail trade.....	1. 60
Dry cleaning.....	1. 67	Secretarial.....	2. 50
Farm labor.....	2. 38	Telephone operator.....	2. 16
Gas station attendant.....	1. 80	Waitress/waiter.....	. 82
General store.....	1. 70	Wholesale trade.....	2. 80
Motels/hotels.....	1. 69	Waste water treatment.....	1. 80

¹ Source: Bureau of Labor Statistics—Estimates of jobs and pay rates in which Opportunities for Families recipients might be placed in or trained for. Testimony of Secretary James D. Hodgson submitted to Committee on Finance, first session on H.R. 1, 1971.

TABLE IV.—SPENDABLE INCOME^{1,2} AS A PERCENTAGE OF GROSS INCOME FOR A FAMILY OF 4

Category	Gross average weekly earnings	Spendable average weekly earnings	Percentage of gross earnings that is spendable
Total private.....	\$129	\$112	87
Mining.....	173	149	86
Construction.....	216	185	86
Manufacturing.....	143	124	87
Transportation, utilities.....	177	155	88
Wholesale/retail.....	120	91	89
Finance, insurance, real estate.....	121	107	88
Services.....	104	93	89

¹ The earnings figures used in the analysis are gross earnings—the amount earned before deductions for Federal social security and income taxes. This approach, in effect, under-estimates the impact of the guaranteed income plans that are analyzed because taxes would not be paid on welfare payments. The magnitude of this underestimation can be seen from the above table. Spendable income was used in the case of the "Javits amendment". Spendable income derived by assuming 13 percent deduction for Federal social security and income tax.

² Derived from September 1971 data published in Employment and Earnings, vol. 18, No. 5, November 1971, U.S. Department of Labor, B.L.S.

TABLE V.—COMPARISON¹ OF AVERAGE HOURLY EARNINGS BY STATE, TO THE SALARY LEVELS REQUIRED TO GET AN INDIVIDUAL OFF WELFARE (FAMILY OF 4)

State	Eliminate welfare payments	Average hourly earnings	State	Eliminate welfare payments	Average hourly earnings
Alabama.....	\$2. 43	\$2. 83	Montana.....	2. 41	3. 50
Alaska.....	3. 96	4. 93	Nebraska.....	3. 33	3. 18
Arizona.....	2. 66	3. 28	Nevada.....	3. 21	4. 06
Arkansas.....	2. 07	2. 45	New Hampshire.....	3. 01	2. 72
California.....	3. 31	3. 75	New Jersey.....	3. 48	3. 39
Colorado.....	2. 48	3. 50	New Mexico.....	2. 19	2. 68
Connecticut.....	3. 33	3. 40	New York.....	3. 38	3. 41
Delaware.....	2. 48	3. 34	North Carolina.....	2. 07	2. 45
District of Columbia.....	2. 50	3. 72	North Dakota.....	2. 71	2. 94
Florida.....	2. 37	2. 83	Ohio.....	2. 17	3. 76
Georgia.....	2. 23	2. 63	Oklahoma.....	2. 07	3. 06
Hawaii.....	2. 73	3. 24	Oregon.....	2. 38	3. 74
Idaho.....	2. 54	3. 15	Pennsylvania.....	3. 18	3. 30
Illinois.....	2. 90	3. 62	Rhode Island.....	2. 73	2. 82
Indiana.....	3. 26	3. 67	South Carolina.....	2. 14	2. 48
Iowa.....	2. 55	3. 64	South Dakota.....	3. 06	2. 98
Kansas.....	2. 55	3. 14	Tennessee.....	2. 31	2. 69
Kentucky.....	2. 31	3. 23	Texas.....	2. 07	3. 14
Louisiana.....	2. 28	3. 55	Utah.....	2. 26	3. 44
Maine.....	3. 50	2. 64	Vermont.....	3. 10	2. 89
Maryland.....	2. 13	3. 36	Virginia.....	2. 72	2. 71
Massachusetts.....	3. 19	3. 19	Washington.....	3. 09	4. 02
Michigan.....	2. 73	4. 12	West Virginia.....	2. 07	3. 36
Minnesota.....	3. 47	3. 47	Wisconsin.....	2. 31	3. 58
Mississippi.....	2. 45	2. 40	Wyoming.....	2. 75	3. 29
Missouri.....	3. 29	3. 21			

¹ Sources: Hourly earnings data, Employment and Earnings, Department of Labor, BLS, April 1970. Eliminate welfare payments data fare from testimony submitted by Secretary James D. Hodgson to Committee on Finance, 1st sess. only H.R. 1, 1971.

TABLE VI.—ESTIMATES OF NUMBER OF JOBS AFFECTED BY THE JAVITS AMENDMENT FOR SELECTED STATES

State	Manufacturing sector	Trade sector	Finance/ insurance	Services	Total
Alabama.....	216,000	180,000	24,000	22,000	244,000
Arizona.....	43,000	84,000	-----	37,000	164,000
Arkansas.....	143,000	102,000	20,000	68,000	333,000
Connecticut.....	58,000	160,000	-----	70,000	288,000
Georgia.....	367,000	250,000	5,000	130,000	752,000
Idaho.....	15,000	36,000	-----	15,000	66,000
Indiana.....	63,000	56,000	-----	30,000	149,000
Iowa.....	17,000	83,000	-----	98,000	198,000
New York.....	647,000	721,000	-----	238,000	1,606,000

¹ Estimates of the number of jobs affected by the amendment of Senator Javits are derived from Employment and Earnings by States and Areas, Bureau of Labor Statistics, estimates based on spendable income (see table IV).

Senator TALMADGE. I see Senator Hatfield has arrived. He wanted the privilege of introducing the witness from his State and we will now recognize Senator Hatfield and he will introduce the next witness.

Senator, we are delighted to have you before the Finance Committee, and you may proceed, sir.

Senator HATFIELD. Thank you very much, Mr. Chairman.

Mr. Chairman and members of the committee, it is my pleasure to introduce to you today several very outstanding women of the community of Eugene, Oreg. Testifying on their behalf is Mrs. Wilt, president of the Aid to Dependent Children Association of Lane County, Oreg., and with her are Mrs. Robin Derringer, Mrs. Patricia Ban, Mrs. Loretta Daniel. All of these women are here today because of contributions that were made to provide them with the transportation expenses to come and testify before this committee and all are recipients of the Federal-State welfare program, but they have taken very unique constructive initiatives to educate themselves for jobs so that they may leave the welfare rolls.

They are also working constructively and with quiet effectiveness with State and local authorities, with members of the State Legislature of Oregon, and with the local community college and the University of Oregon at Eugene to help educate, provide educational opportunities and scholarships for other recipients.

In the process they have been reeducating the citizens of Oregon, changing the image of those who receive welfare aid. They will submit testimony not only as to what they believe should be done about the present and proposed welfare program but will try to apprise the committee of the tremendously worthwhile self-help programs which they have in operation and have had for several years.

Mr. Chairman, too often the newspapers spread only the sensational and the bad news about those on welfare rolls, just as they print oftentimes too much of the negative and destructive forces at work in our political system, which has led to great polarization and estrangement between social groups. The media too often ignore the quiet constructive efforts of hundreds of women and men such as underway in the State of Oregon, and those who will testify today from my State, to help themselves and in turn to help others in the community. They have done so much to relieve the human suffering and hopelessness which are characteristic of those who think no one cares and have brought hope and a chance for a changed life to many people.

Mr. Chairman, I commend them to you, and trust that the committee will listen deeply as to what they have to say, and I am very grateful for this opportunity to introduce to you at this time Mrs. Wilt and these other women, and to say that I have left my hearing in the Commerce Committee on environmental problems of the urban poor and, therefore, with your permission I would like at this time to turn the microphone over to Mrs. Wilt and leave her in the good hands of your committee.

Senator TALMADGE. Thank you, Senator Hatfield.

Mrs. Wilt, will you invite the other ladies to take seats at the witness table, please.

STATEMENT OF MRS. LYNDA WILT, PRESIDENT, AID TO DEPENDENT CHILDREN ASSOCIATION OF LANE COUNTY, OREG.; ACCOMPANIED BY MRS. PATRICIA BAN, MRS. ROBIN DERRINGER, AND MRS. LORETTA DANIEL

Mrs. WILT. Thank you, I will, Senator.

Mr. Chairman and members of the committee, I am Lynda Wilt and I am president of the ADC Association of Lane County in Eugene, Oreg. I am testifying today on behalf of the federated self-help groups of Oregon.

The materials we have entered as testimony will indicate the extent of the self-help programs and their effectiveness in Oregon. These are programs designed by the poor, implemented by the poor and financed through the efforts of the poor.

Under H.R. 1 most of our programs will be discontinued. Our scholarship program, the telephone aides program, and the Confidence Clinic will be eliminated. We have several alternatives we would like to suggest to this committee. We would suggest that the Federal Government allow the States to pay up the number of quarters that anyone on welfare is lacking, so that the aged, blind, and disabled can be eligible for total social security benefits. The Federal Government should incorporate Federal regulations which state that all States are required to adopt ADC-UN programs to eliminate the increase in family breakdown. They should eliminate certain categories of need, and substitute categories for people in need. The Federal Government should establish a Federal minimum standard of living for each area. On acceptance of these standards, the Federal Government would assume the cost on a 9-to-1 matching basis. The Federal Government should recognize their responsibility for all people in need. In particular, we refer to those persons currently declared as unmatchable. For example, those currently receiving unemployment, those receiving workman's compensation, and those receiving general assistance. They should guarantee basic training and development funds for innovative programs designed by the poor.

It has long been accepted as a part of our industrialized society that those who work hard are entitled to the goods of our society. It is time we recognized that this concept is not necessarily true. Tell the unemployed aircraft workers from Seattle that they did not work hard. Tell the unemployed workers from the closed factories that have now relocated in Thailand, Samoa, and other underdeveloped countries that

they did not work hard. But tell them that children are now working in some of those factories, and they apparently do work hard.

It is time that this country responded to the necessity of a guaranteed income for the poor. These standards must be set at one of the more realistic levels set by the Department of Agriculture. The guaranteed income not unlike the present welfare system would merely designate a larger amount of money passing through the hands of the poor, directly back into the local economy. A guaranteed income for the poor merely follows the precedent introduced by the middle class in the form of soil banks, civil service, teacher tenure, and oil depletion allowance.

The poor of this country are not depositing their money in Swiss banks. They are not buying tax free school bonds, municipal bonds, or State bonds. They are not investing money in ventures that will pay off far into the future, thus adding to the already pressing problem, of not enough money in circulation. They are taking their monthly welfare checks, and immediately sending them back to middle-class pockets. They pay rent, heating, and light bills, buy food and clothing. The money they receive goes directly back into the economy to keep it moving. I submit to you at this time, that welfare was never created to take care of people, but to take care of an economy that depends on money passing through many hands to stay alive.

The increase in the number of ADC recipients is not the result of self-inflicted wounds; it is the result of a society that has broken down. This society no longer pays off for hard work, for education, or for wanting to be a good parent.

We are aware that no one should be exempt from the due process of law, but due process should also include equal opportunity. Equal opportunity to choose one's destiny, equal opportunity to live in decent housing and partake of adequate nourishment, to be properly clothed, and to participate in the decisionmaking policies of our Government.

The federated self-help groups of Oregon are an example of the poor in this country who have been involved. We are involved at the State and local levels of our Government, we are involved with agencies, civic groups, fraternal organizations, education, and the working classes. We have proven that the poor can be responsible and concerned for the future of our country. They are concerned with the decisions their lawmakers are called upon to make. They are aware of the low priority given to their wishes, to their hopes, and their dreams. They resent handouts, condescending attitudes, and categorizing. They resent the lack of response to their cries for understanding. They will respond to any offer of involvement in their future, or to any hope for opportunity. Basically, they are reiterating again and again that when a man is starving, give him a hook and line, not a fish.

H.R. 1 is not welfare reform. It will not cure the disease of poverty, nor will it put all the poor to work. It will provide an avenue to build a new bureaucracy designed to administer a "get tough" policy, which is doomed to failure. This new bureaucracy will not be trained in the problems of the poor, they will not be trained in the problems of society. The new bureaucracy will learn as the charitable workers of the 1800's did, that poverty is a result of the society, not the sin of the poor.

We are not living in the 1800's nor are the poor as ignorant as their earlier counterparts. True reform must incorporate incentive, equality of opportunity, and due process of law.

We must question whether or not H.R. 1 is true reform. Does it incorporate equality of opportunity and the due process of law, as guaranteed under the Constitution? If it does not guarantee the rights and opportunities for all citizens, then it cannot be reform, it becomes repression.

You must examine the constitutionality and the intent of H.R. 1. We have merely brought to your attention some of our feelings concerning H.R. 1, a few suggestions for alternatives, and a showing that self-help programs in Oregon are working.

Thank you.

Senator TALMADGE. Thank you very much, Mrs. Wilt. I have scanned through your complete testimony, and I want to compliment you on it. I intend to read your entire statement.

Any questions?

Mrs. WILT. Thank you.

Senator TALMADGE. Thank you, we are honored indeed to have you before our committee.

Senator HARRIS.

Senator HARRIS. First of all I want to say that I am really impressed by your testimony and I appreciate it. I agree with what you have said. I wonder if the other women with you might introduce themselves and say something about their own background and interest in this subject.

Mrs. WILT. I think that would be very good.

Mrs. DERRINGER. Robin Derringer, I have one child and a disabled husband at home. I am a full-time student at the University of Oregon on our ADC scholarship. I am a member of the executive board of the Lane County Association and I am a member of John Galvin's advisory board in the State of Oregon and involved in other activities.

Senator HARRIS. Do you receive aid to dependent children?

Mrs. DERRINGER. Yes, I am on welfare.

Senator HARRIS. How much do you get?

Mrs. DERRINGER. We get \$204 a month for a family of three.

Senator HARRIS. What is the ADC scholarship, you mentioned it. How are its funds raised?

Mrs. WILT. Our funds for our scholarship program are raised on a local level. We raise the first dollar and then they are matched 3 to 1 by the Federal Government. This term we have 300 people in school and it has been quite a problem raising money for all of them. All of the money is raised locally though and raised by the recipients.

Senator HARRIS. What about your own situation? You didn't talk about yourself personally.

Mrs. WILT. About me?

Senator HARRIS. Yes.

Mrs. WILT. I am Lynda Wilt, and president of the Lane County ADC Association. I am also a full-time student. I carried 18 hours last year and came out with a 3.8 average. I am on John Galvin's board, who is the John Galvin who is head of the advisory board and I am also on numerous resource activities, and we also help in the University of Oregon teaching the classes.

Senator HARRIS. Do you receive aid to dependent children?

Mrs. WILT. Yes.

Senator HARRIS. How much do you receive?

Mrs. WILT. I have two children, a daughter 10 and son 8, and receive \$204 a month.

Senator HARRIS. And you?

Mrs. DANIEL. I am Loretta Daniel, 49 years old. I am a University of Oregon student and also a part-time teacher. I teach classes in the community services and public affairs school. I made a 3.85 last term to, I carried 14 hours. I have four children, two are married, one is married to the director of the mentally retarded program in Medford. My other daughter is attending graduate school. My third daughter is at Antioch College on a scholarship. My fourth daughter is 16 and she is a freshman at college. I serve on the Governor's advisory board. I serve on the scholarship committee and I am legislative chairman for the ADC Association.

Mrs. BAN. My name is Patricia Ban and I am 28 years old, I have three children, I have a son 9½ and twin daughters who are 8, and I serve on—I am a full-time student at the University of Oregon, also. I serve on John Galvin's advisory committee also. I serve on an advisory committee at Lane Community College. I also serve on an advisory, or on the board for the county commissioners. I have been active in and involved in the ADC Association for approximately 2 years now.

Senator HARRIS. What would you all do if you didn't have aid to dependent children?

Mrs. DANIEL. We wouldn't be able to feed our children. I am probably the only one who receives aid for the disabled.

Senator HARRIS. You are?

Mrs. DANIEL. Yes, I have a heart condition.

Senator HARRIS. It is really wonderful to see people like you doing the thing you are doing.

What about the work provisions in H.R. 1? Do you know anything about that? What do you think about going to work and putting your children in substandard day care and other similar aspects of H.R. 1?

Mrs. WILT. Robin is probably better qualified, she has been going through the Talmadge amendments.

I guess one of the things I would question in the work amendments is how well they are working presently and I think all we have to do is look at the present features on the WIN program, the statistics that are available, to know that those programs are not working. I think that the WIN, according to the statistics, less than 50 percent of the people who are on the WIN program complete it. I think our program will bear out the fact that we have a, pretty close to a, 70 percent employment rate when our people are through with their training. This last terms of our 200 students that we had in school, 89 percent of them had 2 or better grade averages which is an average. Thirty-nine percent of our people were on the honor roll which is a 3 or better.

I think also under the child-care provisions that I would question, and I know several witnesses before me mentioned the day-care recipients taking care of other recipients' children, and I guess I would question, the fact as to, you know, why this has to be. Perhaps they are not qualified or perhaps that is not what they really want, and I

think by locking them into a day-care or living room day-care situation, we are not eliminating the poverty. What we are doing is telling those people "You must be satisfied with what we are giving you and we will not be giving you a chance to get off welfare," because obviously they cannot when they are being paid \$90 a month to baby sit.

Senator HARRIS. Anybody else want to comment on that? Robin, who takes care of your children while you go to school?

Mrs. WILT. I have been very fortunate. I tried to arrange my classrooms around the time when my children are in school. This isn't always possible and when it isn't I use a private babysitter.

Senator HARRIS. Do you think that women who can work would voluntarily work if they had day care and a job available to them?

Mrs. WILT. Yes, I believe they would. I think that what we have done is not allow for options of going to work. We have said, "We will set all obstacles in your way, and if you can make it by it, then you have pulled yourself up by your bootstraps and done a fine job." But what we are not doing is clearing the way and showing there are options available. We are telling them, "You have to be a secretary or you have to be a welder." We are not saying to them, "We are going to provide these options, and you choose what you are best qualified to do."

Senator HARRIS. Do you have any feelings one way or the other about saying to a mother she must leave her children in a day care center and take a job whether she wants to or not?

Mrs. WILT. Yes, I do. I am sure that we recognize that not all of the citizens in our country are qualified or have the initiative or the feeling that they must work, and I think this is exemplified very much by the middle class. What we are saying is, if you are married and if you marry well enough, then you don't have to work. But if you have not had that option available, or if you have not provided that for yourself, then you must go to work, and what we are doing is cutting off one group of our society.

Senator HARRIS. Thank you very much.

Senator TALMADGE. Thank you very much.

Any further questions? We appreciate your appearing, and you made an excellent statement.

Mrs. WILT. Thank you.

(The prepared statement of Mrs. Wilt with attachments follows. Hearing continues on p. 2352.)

PREPARED STATEMENT OF LYNIDIA WILT, PRESIDENT, AID TO DEPENDENT CHILDREN
ASSOCIATION OF LANE COUNTY, OREG.

I am Lyndia Wilt. I am president of the A.D.C. Association of Lane County, Oregon. I am testifying today in behalf of the federated self-help groups of Oregon.

The materials we have entered as testimony will indicate the extent of the self-help programs and their effectiveness in Oregon. These are programs designed by the poor, implemented by the poor, and financed through the efforts of the poor.

Under H.R. 1 most of our programs will be discontinued. Our scholarship program, the telephone aides program, and the Confidence Clinic will be eliminated. We would suggest that the federal government allow the states to pay up the number of quarters that anyone on welfare is lacking, so that the aged, blind

and disabled can be eligible for total Social Security benefits. The federal government should incorporate federal regulations which state that all states are required to adopt A.D.C.-UN programs to eliminate the increase in family breakdown. They should eliminate certain categories of need, and substitute categories for people in need. The federal government should establish a federal minimum standard of living for each area. On acceptance of these standards, the federal government would assume the cost on a 9 to 1 matching basis. The federal government should recognize their responsibility for all people in need. In particular, we refer to those persons currently declared as unmatchable. For example, those currently receiving unemployment, those receiving workman's compensation, and those receiving general assistance. They should guarantee basic training and development funds for innovative programs designed by the poor.

It has long been accepted as a part of our industrialized society that those who work hard are entitled to the goods of our society. It is time we recognized that this concept is not necessarily true. Tell the unemployed aircraft workers from Seattle that they did not work hard. Tell the unemployed workers from the closed factories that have now relocated in Thailand, Samoa and other underdeveloped countries that they did not work hard. But tell them that children are now working in some of those factories, and they apparently do work hard.

It is time that this country responded to the necessity of a guaranteed income for the poor. These standards must be set at one of the more realistic levels set by the Department of Agriculture. The guaranteed income not unlike the present welfare system would merely designate a larger amount of money passing through the hands of the poor, directly back into the local economy. A guaranteed income for the poor merely follows the precedent introduced by the middle class in the form of soil banks, civil service, teacher tenure and oil depletion allowance.

The poor of this country are not depositing their money in Swiss banks. They are not buying tax free school bonds, municipal bonds or state bonds. They are not investing money in ventures that will pay off far into the future, thus adding to the already pressing problem, of not enough money in circulation. They are taking their monthly welfare checks, and immediately sending them back to middle class pockets. They pay rent, heating and light bills, buy food and clothing. The money they receive goes directly back into the economy to keep it moving. I submit to you at this time, that welfare was never created to take care of people, but to take care of an economy that depends on money passing through many hands to stay alive.

The increase in the number of A.D.C. recipients is not the result of self-inflicted wounds; it is the result of a society that has broken down. This society no longer pays off for hard work, for education, or for wanting to be a good parent.

We are aware that no one should be exempt from the due process of law, but due process should also include equal opportunity. Equal opportunity to choose one's destiny, equal opportunity to live in decent housing and partake of adequate nourishment, to be properly clothed and to participate in the decision-making policies of our government.

The federated self-help groups of Oregon are an example of the poor in this country who have been involved. We are involved at the state and local levels of our government, we are involved with agencies, civic groups, fraternal organizations, education and the working classes. We have proven that the poor can be responsible and concerned for the future of our country. They are concerned with the decisions their law makers are called upon to make. They are aware of the low priority given to the wishes, hopes and dreams of their class. They resent hand-outs, condescending attitudes and categorizing. They resent the lack of response to their cries for understanding. They will respond to any offer of involvement in their future, or to any hope for opportunity. Basically, they are reiterating again and again that when a man is starving, give him a hook and line, not a fish.

H.R. 1 is not welfare reform. It will not cure the disease of poverty, nor will it put all the poor to work. It will provide an avenue to build a new bureaucracy designed to administer a "get tough" policy, which is doomed to failure. This new bureaucracy will not be trained in the problems of the poor, they will not be trained in the problems of society. The new bureaucracy will learn as the charitable workers of the 1800's did, that poverty is a result of the society, not the sin of the poor.

We are not living in the 1800's nor are the poor as ignorant as their earlier counterparts. True reform must incorporate incentive, equality of opportunity and due process of law.

We must question whether or not H.R. 1 is true reform. Does it incorporate equality of opportunity and the due process of law, as guaranteed under the constitution? If it does not guarantee the rights and opportunities for all citizens, then it cannot be reform, it becomes repression.

You must examine the constitutionality and the intent of H.R. 1. We have merely brought to your attention some of our feeling concerning H.R. 1, a few suggestions for alternatives, and a showing that self-help programs in Oregon are working.

REVIEW OF H.R. 1

I. H.R. 1 establishes an eligibility scheme that excluded many classifications of needy persons from welfare benefits. Generally, H.R. 1, provided that certain families, as defined in the act, are eligible for benefits. A family, in order to be eligible, must contain at least two or more individuals at least one of whom is a child. (Section 2155(a) (4). This definition excluded the following persons:

- (a) the single person over the age of 18 who are childless.
- (b) married couples without children or whose children are over the age of 18 and not attending school.
- (c) a single woman who is pregnant and has no other children.
- (d) an unmarried person whose child is over the age of 18 and not attending school.

Undoubtedly other classifications of ineligible persons can be derived from the restrictive definition of family as defined in the act.

The above classifications are derived from the definition of "family" as found in Section 2155(a) (4). There is one significant and specific exclusion found in the act. *If the head of the household is a full time undergraduate or graduate student at a college or university*, he or she is excluded from the benefits, Section 2155(a) (4) (a).

II. General eligibility requirements

Every eligible family is entitled to benefits upon registration for manpower training and employment, Section 2102. Those individuals who are determined by the Secretary of HEW to be a member of an eligible family and available for employment, must register with the Secretary of Labor for man-power services, training, and employment, Section 2111(a).

If the Secretary determines that an individual is unable to engage in work training by reason of illness, incapacity, or advanced age, he is not required to accept employment, Section 2111(b) (1). Until July 1, 1974, a mother of a child under the age of six is not eligible for employment. Thereafter, a mother of a child under the age of three is not eligible for employment, Section 2111(b) (2).

The only standards for the employability of an individual is whether he is able to engage in work or training by reason of illness, incapacity or advanced age. There is not requirement that the work be suitable or gainful. The act specifically requires that employment cannot be refused if the wages for the work offered are at an hourly rate of not less than $\frac{3}{4}$ of the minimum wage. As specified in Section 6(a) (1) of the fair labor standards act of 1938, Section 2111(c) (2) (d). The effect of this provision would create a vast pool of unskilled cheap labor that would be utilized by industries that were not subject to the fair labor standards act. These persons could be compelled to work for the sum of \$1.20 per hr. gross, or otherwise be ineligible for benefits provided in H.R. 1. The act contemplates that women with children will be deemed employable.

The act therefore provides that childcare and other supportive services will be provided. Section 2112. The Secretary of Labor is authorized to make provisions for the furnishing of childcare services. There appears to be no provision in the act that allows a mother to decline child-care services if they are at an inconvenient location, or unsuitable because of unsafe or unsanitary conditions. Therefore, it is not clear whether a mother who declines employment because of the unavailability of suitable childcare facilities would remain eligible under the act for benefits, because there are no provisions in the act allowing her to justifiably refuse employment under these conditions. It is likely that the Secretary would determine that she was ineligible. The Secretary of HEW must establish standards assuring the quality of child care services, Section 2134.

III. Eligibility for an amount of benefits

Resources of an eligible family cannot exceed \$1,500, Section 2152(a) (2). The Secretary of HEW has the power to determine the resources of a family that should be excluded from the \$1,500 maximum. The Secretary has the power to determine the value of the home that should be excluded or included in the \$1,500 maximum as well as the value of the household goods, personal effects and other property which the Secretary deems essential to the families means of support, Section 2154(a).

These guidelines have not been formulated. In cases where The Secretary determines that a family has assets above the \$1,500 maximum that are not excludable, he can prescribe a period or periods of time and the manner in which this property shall be liquidated. The funds that the family receives through this liquidation process is considered an overpayment if benefits are being paid during the time of disposal, Section 2154(b). The amount of benefits for a family are paid at the rate of \$800 yearly for each of the first 2 members, plus \$400 yearly for each of the next 3 members, plus \$300 yearly for each of the next 2 members, plus \$200 for the next member, Section 2152(b).

The act, therefore, clearly does not compensate eligible families that are greater than 8 in number.

The amount of benefits payable initially to an eligible family must be based upon the Secretary's estimate of the families income for such quarter.

The Secretary must take into account the families income from preceding quarters in any modifications which are likely to occur on the basis of change of circumstances or conditions. The amount of benefits payable to any family for any quarter of a calendar year shall be determined by the Secretary in the quarter immediately following such quarter; and, to the extent that the amount actually paid to such family for such quarter; was more or less than the amount so determined, proper adjustment, or recovery can be made, Section 2152(d) (1). This would allow the Secretary to deny benefits to the family whose earnings for appreciating quarters were high in relation to the benefits that they would be entitled to receive under the act. The act undoubtedly contemplates that the family has "saved" this difference when in fact it may not have been saved because it was necessary to apply these sums on pre-existing family indebtedness.

IV. The hearing process

H.R. 1 specifically allows the Secretary to make determinations that would deny benefits, recover overpayments, and assess penalties without a prior hearing. The Secretary can make adjustments for overpayments, Section 2152(d) (2), and assess penalties and fines if certain data is not furnished. Section 2031(e) (1) and redetermines benefit levels at any time he receives notice or has reason to believe there has been a material change in the families circumstances, Section 2152 (d) (1).

The impact of the Secretary's power is that benefits can be denied, curtailed or fines imposed without a prior hearing. The Supreme Court of the United States has repeatedly held that once a person is entitled to benefits that they cannot be limited, withdrawn, or denied without a prior hearing. This casts a serious constitutional question on the validity of the hearing provisions.

In all such cases, the recipient must request a hearing after the fact and carry the burden of proof that the Secretary's action was unwarranted. This invokes a hearing process that is equally oppressive.

HISTORICAL BACKGROUND OF THE LANE COUNTY ADC ASSOCIATION

Prior to the 1966 state general election, the Y-ettes (a recipient group taking part in a socialization training program of YM/WCA and the welfare department) were encouraged to sponsor a candidate fair. The candidates fair was an opportunity for all those people running for state and local positions to appear as a group to speak on the welfare issues. As a result of the candidates fair, interested members of the Y-ettes, the mother's group sponsored by the Lutheran Family Services Friendly House counseling group, and other welfare recipients began meeting informally to discuss what they needed to do about some of the more common problems shared by welfare recipients. Although they were well aware that there was an urgent need for changing policy, laws, rules and regulations pertaining to welfare, the immediate needs of the group were related to survival. It was just before Christmas, and the most loudly

voiced question was, "How can we get free Christmas trees, and free turkeys, so we can still buy a toy for the children." This is an indication of why it is essential for poor people to be in charge of their own groups, because only poor people could understand that you can not solve state or national problems of the poor until you have solved your own immediate needs of food, shelter, and clothing.

With the help of Vista volunteers, and the co-operation of the Forest Service, they arranged for the cutting and delivery of truck loads of Christmas trees. With the help of friends and businessmen in the community they were able to supply turkeys at a drastic discount. They referred to the turkeys as disabled rejects, since they came to them with various portions of their anatomy missing; such as a missing wing, neck, leg, or large patches of skin . . . but they were turkeys and they were *very* cheap.

Once the group had satisfied its immediate needs it was willing to look at some of the reasons behind those needs. Again, with the assistance of some Vista volunteers, the group learned how to draw up its statement of purpose, and gave the organization a name; ADC Association of Lane County.

They realized that using "ADC" as part of their legal name would classify them solidly within the welfare stereotype, but they also agreed that they could use this label to their advantage and work to reduce the stigma that had always been attached to it.

In formulating the initial operational strategy, they borrowed liberally from a beginner's book on public relations that they found at the public library (these books are abundant and may be very useful to groups that are in their formative stages). Some of the ideas that they adopted from this book and that have been used are:

- a. To present ourselves honestly, including admitting our condition and dealing with it straightforwardly.
- b. To be willing to be questioned on any point dealing with our own personal situations and to discuss openly the causes of our being on public assistance. (It should be mentioned that any member who was unwilling to follow these precepts was encouraged to participate in areas that did not involve public representation.)
- c. To be representative in appearance and thought of all recipients as much as possible, thus avoiding the extension of our own personalities into issues that really belong to an entire class.
- d. To use a factual, informative approach and to avoid emotionalism in presenting issues.
- e. To use peer groups in bringing pressure to bear on the people we are trying to convince.

In short, they learned how to use "the system" for the benefit of the people represented. The next step was to work up the constitution and by-laws, and file for articles of incorporation.

They came to an agreement, by consensus, that they would follow a line of public relations procedures, using as their motto, "When a man is starving, don't give him a fish . . . give him a hook and line and teach him to fish for himself". Getting input from the entire Association now that they had a statement of purpose, constitution and by-laws, was made much easier because the association had a direction in which to go. From there they could concentrate on changes that were needed for the entire recipient population. They chose the things that they felt were to be achieved immediately. They realized that some goals would take a little longer, perhaps as long as ten years. They proceeded to recruit sympathetic local people who were not politicians, but who had experience dealing within the political arena. These people worked as associate members. They were from both political parties and from all educational backgrounds, i.e., sociologists, psychologists, economists, representatives from business, social work, education, law, and public administration. Other valuable associates were ex-legislators and the wives of politically influential persons within the community.

They were also fortunate in finding a film which was designed to teach people how to get a bill written, sponsored, and how to lobby in the legislature. The thirty minute movie was nothing like the real thing, and they couldn't see the long educational process ahead of them for the next six years. The movie made the process look simple, and motivated them to action. They soon realized that there was no better way to learn than by experience.

Don't hesitate in getting involved because you're afraid of making mistakes. Every session mistakes have been made, however, we have profited from those mistakes, and avoided making them a second time. For instance, during the first session the "hard sell" was given to a man thought to be a legislator, only to find out he was the man from the supply room. From then on identity was an essential part of the format.

This drive to learn, also drove our lobbyists to the need to be there representing the group, even when they were working under adverse conditions. For instance, one of the two people who was going to the legislature was suffering from an attack of asthma complicated by emphysema. One day it was decided that she would sit in the ladies room which had a cot in it and would rest while the other member of the team did the leg work. After a period of two hours the leg man returned to reports that she had gotten three legislators to sign the bills. With a gasp, the reclining lobbyist replied, "I have been working too. I have been catching the lady legislators as they came through here. It's like having my own office." It generated the natural reply, "You may have your own office but you're sure limiting your clientele with the sign you have outside."

The next step was to take the ideas that were felt to be attainable, present them to a sympathetic legislator and have them drawn into legal bill form. Note: don't ever put all your eggs in one basket; the mistake first session was in allowing one liberal legislator to be the chief sponsor of all the Association's bills. Unfortunately, they were not aware that they would also inherit all of his enemies, which would cause future problems in getting the bills out of committee. Our tactics in later legislative session were to strategically divide the bills between the House and Senate and to get conservative legislators to sponsor them. Our reason for doing this will become clear in any lobbying effort that is undertaken by anyone.

While the lobbying effort was in progress, other members of the Association were reading and absorbing information on subjects that ranged from child care to legal procedure. They were investigating ways to fund the Association, by looking at the possibility of O.E.O. funds, and other agencies monies. The Association chose not to accept any funding if it necessitated relinquishing their self-governing principles. Since they found that usually there were stipulations requiring that relinquishment, they looked elsewhere for funding. Since the need for funds was present, some of the members worked on cake sales, rummage sales, movies, dinners and other fund raising projects. This money was partially used for expenses incurred in lobbying. One of these expenses was a result of the lobbyists having to coax the life out of a series of old cars owned by the members of the Association, in order to get to the capitol which was eighty miles away. Besides the expense of gas, the lobbyists also found that they had to have a lunch every day and parking. Certs were essential so the lobbyists did not "bad mouth" the legislators.

Other members were engaged in recruiting new members in order to get more welfare recipients involved in determining the goals of the Association. Still others were mailing out news-letters informing recipients in the county about the activities and how they could participate. The news-letters were put out with money contributed by some friends within the community. They were run off on different mimeograph machines from churches, university departments, and business people. They rotated the use of equipment in order to keep as many community groups as possible involved in their progress. They took it to the first person that expressed an interest and told them it was the only copy that they had. If they wanted to use it to make a copy for themselves they were asked to make a few extras for the Association. Research in the law library was being done by another committee in order to back up testimony for the lobbyists. People were recruiting by personal contact, telephone, and other means.

The willingness to work led to the programs that exist today. The cohesiveness of the people involved has led to the success of those programs. For the first time there were alternatives.

NEIGHBORHOOD VOLUNTEERS PROGRAM

Plan.—To recruit, train and make use of Public Welfare recipients in supplementing social services for the purpose of improving understanding between recipients and social service staff; improving understanding of human resources and of the Public Welfare Department. The primary technique is the use of the

telephone in geographically distant areas. Recipients are recruited because of their connection with the informal communication network among low-income people. It has been demonstrated that recipients find it easier to seek information from their peers.

Need for this service.—Public Welfare recipients are residing in areas which are geographically distant or isolated from the County Welfare Office. Most recipients do not have telephones and must borrow a neighbor's phone or use a pay phone. Telephone communications between recipients and service workers are usually lengthy and frequently in response to a crisis situation. Telephone lines into the office are frequently busy so the caller must wait. A neighborhood volunteer can channel telephone calls by knowing who to call for help. The call itself is usually briefer when the volunteer is calling in behalf of the recipient, thus saving some caseworker time. Geographical isolation from the county office presents a transportation problem. Almost no small community has adequate public bus transportation. Telephone communication is therefore more important for these people.

Recruitment of neighborhood volunteers is usually done through casework staff who are able to identify those recipients who meet the desired criteria. The caseworker looks for recipients who: (1) have shown an interest in being of help to others; (2) have knowledge of the social and economic conditions in their specific community; (3) have some knowledge of local resources; (4) have demonstrated an identity with and commitment to their community; and (5) are in communication with other low-income people in their area. In addition, the volunteer should have reasonably good health and should be able to drive a car.

Successful recruitment depends upon how well the staff knows their clients. In some areas, client groups or CAP agencies may be able to suggest neighborhood volunteers.

Publicity about the services of a neighborhood volunteer is done through articles in local newspapers and announcements by radio stations. The primary method of notifying the recipients is done by the caseworkers who send letters or notify their clients verbally. Newspaper publicity by itself is not effective since most newspapers do not wish to print telephone numbers.

Activities

The neighborhood volunteer must be available on a twenty-four hour basis to provide advice and help to those recipients who are faced with an emergency arising from a fire, medical needs, housing eviction, and other personal or family crises.

To advise local recipients and residents about the resources of the welfare department, education and training resources, availability of housing, availability of medical care, specialized resources for children, day care and emergency baby sitters.

To advise recipients and residents on how to make use of the resources. To accept and record messages for the caseworker as requested by the agency client, by other community residents, or by the caseworker to be relayed to a specific client.

To provide supplementary service in behalf of the caseworker and to act, when appropriate, as a liaison for the caseworker.

To provide emergency transportation or locate transportation for an agency client.

To notify the caseworker or other appropriate staff of requests for service, date and hour of the request and disposition of the request; and to provide periodic reports.

To help locate and to solicit certain items such as appliances, furniture, or clothing from the local community in order to help the recipient supplement their assistance grant.

The neighborhood volunteer is likely to be in a position to give supportive help in a wide range of situations. Examples are: death in the family, money management, utility shut off, washer breakdown, eviction notices, etc.

The volume of contacts, either in person or by telephone, varies greatly between neighborhood volunteers. Factors influencing activity are: isolation or distance from County Welfare Office, experience and personality of the volunteer, and the density of the client population. An experienced neighborhood volunteer may record as many as 155 contacts a month. Most contacts occur during the

regular working day, and most of the activity revolves around the use of the telephone.

Training the volunteers

Training consists of two parts; initial orientation and on-going training.

1. *Orientation.*—Each neighborhood volunteer should undergo an intensive period of orientation for one week. Included is an in-depth review of public welfare resources and services and other human resources in the community. Each volunteer should be given a resource directory or manual which contains current information about resources. The volunteer should tour the office and meet the county staff. Duties of the volunteer should be discussed with concrete illustrations being used to teach them their functions. The basic function and role of the caseworker should also be discussed. Training responsibility should be centralized in one county staff person who has demonstrated the ability to teach and to communicate with low-income people.

2. *On-going training.*—A monthly session should be planned for the volunteers during which problems should be aired and resolved. Caseworkers should also participate in these sessions, to help clarify the difference in caseworker-volunteer roles. Tours should be planned to other major resource agencies such as: Social Security, Employment Office, Mental Health, CAP, and Legal Aid. During the sessions the training goal should be focused on providing information which is specific and relevant.

Costs

Neighborhood volunteers should be partially paid volunteers. A monthly fee for service should be paid to each volunteer to help them to cover expenses of additional clothing and personal items which they believe to be important in helping them to meet the public. The fee for service also represents a concrete form of recognition for services being given by recipient-volunteers. The monthly telephone charge should be covered as well as the original telephone installation cost when the selected volunteer has no telephone. Reimbursement for private car mileage should be paid when necessary, and child care to enable the volunteer to attend training sessions or to be away from home when providing emergency transportation.

INFORMATION FORUM

On vital issues concerning large portions of welfare population such as medical care, education, food stamps, H.R. 1, etc., we felt that public information forums for welfare recipients and for the general public should be held so that the greatest number of people could have the facts. The way we went about publicizing these forums was to get public service announcements on television, write-ups in newspapers, in Democratic/Republican newsletters, flyers to students and recipients, posters, and word of mouth. In some instances more than one forum was set aside for these depending on content and interest. An example of this was an open forum held in a public hall on H.R. 1 which stimulated a great deal of interest from the general public and the recipients which required many smaller meetings, especially with the League of Women Voters. Members of the League seemed to be upset by our stand on H.R. 1, since we opposed it, so we asked to be put on the agenda of their smaller group meetings where our members presented arguments in opposition to H.R. 1. We also were asked to speak before many classes at the University of Oregon, the University of Oregon YWCA, to labor unions, social concern groups of churches, a community college, granges, honorary sororities, the Lane County Council of Governments, and the City Council. The positive response from these meetings, came in the form of volunteers, for writing letters to legislators, for carrying petitions opposing H.R. 1, raising funds for lobbying and for sending recipients to testify at hearings in Washington, D.C.

Another example.—Results from an informational open forum on medical care for the underprivileged brought about a much better understanding between the medical profession and welfare recipients, an understanding of doctor's problems by recipients, and an agreement between the two groups to work on better medical services for welfare recipients in the county. A system has been devised whereby everyone who needs a doctor may call the county medical office and a doctor's name will be given and he must respond to the request. Sub-standard drug list, i.e., no liquid penicillin, no prophylactics, no fluorides, were brought to the attention of the Association. In turn these grievances were taken to the

Governor's Advisory Committee on Medical Assistance for the Underprivileged by the Association's representative and as a result these items have been added to the drug list. Also, we were asked to elect a representative to attend the meetings of the charitable division of the Lane County Medical Association. In addition the Lane County Medical Association appointed as a consultant the ADC representative from the Governor's Advisory Committee on Medical Assistance for the Underprivileged.

TELEPHONE AIDES PROGRAM

Agreement to purchase services from Neighborhood Aides

The Oregon State Public Welfare Commission agrees to purchase, through the Lane County Public Welfare Commission, specified services from the Lane County ADC Association, to be provided in the communities of: Leaberg, Mapleton, Cottage Grove, Oakridge and Junction City. It is intended that current members of the ADC Association who reside in these communities will be available to clients living in these communities, to provide emergency service and referral services. Services will be available on a twenty-four hour basis to provide advice and help to those recipients who are faced with an emergency arising from a fire, medical needs, housing eviction, etc. The aide is expected to notify the caseworker as soon as the county office is open. The Neighborhood Aide will also be expected to advise local recipients about the resources of the Welfare Department, educational and training agencies, availability of housing, availability of medical care, specialized resources for children, day care and emergency babysitters. The Lane County Welfare Commission staff will prepare lists which identify resources and how to contact resources when the caseworker is not available or when the county staff has requested referral activity from the aide. The aide is expected to keep a record of these activities.

The neighborhood aide will also be expected to take messages for the caseworker as requested by the welfare recipient, by other community members or by the caseworker to be relayed to a specific recipient. It is intended by this agreement, that the neighborhood aide be available to provide supplementary service in behalf of the caseworker and to act, when appropriate, as a liaison for the caseworker. The neighborhood aide will not act for the caseworker, unless specifically requested to represent that caseworker.

Training of the neighborhood aide will be carried out by designated staff of the Lane County Welfare Commission with consultation from rs. Loretta Daniel. Training will include knowledge about community resources, the Assistance and Service Programs of the Lane County Welfare Commission, telephone techniques, etc. On-going consultation will be made available by the Lane County staff. The resources of the staff of the State Public Welfare Commission will be made available. Expenses to be covered by this agreement include installation of a telephone when necessary, the monthly telephone bill and a thirty dollar fee per month. The Lane County Public Welfare Commission will be billed by the Lane County ADC Association who will handle the reimbursement of the individual Neighborhood Aide.

The period of time to be covered by this agreement will begin _____ and will continue in effect until _____.

SPEAKERS BUREAU

The Speakers Bureau was developed because of our lobbying efforts at the State Legislature. Many groups in the community were interested as to why we went to the legislature and the results of our efforts. Because the burden of these speaking requests fell on two people, it was necessary to develop more versatility in the group.

Buddy System.—The simplest way to remedy the situation was to divide into two groups, with each experienced speaker taking and inexperienced member to a speaking engagement. As the member developed experience, she in turn subdivided and took a new member along. The least experienced member spoke before small groups and as they gained experience, moved to appearing before large groups; they started with WIN orientations, university classes, business sororities, churches, civic clubs, and to Demo forums, conferences, and eventually to participating in lobbying efforts. The main things we found to develop confidence in conjunction with speaking, was to give our people vast amounts of information on welfare policy, law conditions, housing, food stamps, medical aid, and our own

programs, (statistics, etc.; and, always, *to work in pairs*). We also found it essential for success, to be frank, open, and willing to discuss personal experiences in public.

The Flash Card System.—People who were very timid about giving speeches, used note cards with brief reminders concerning essential points. From these notes and from the information they accumulated, it was easier to go through lengthy speeches.

Results derived from the speakers bureau have been: contributions for transportation to the legislature, for our scholarship program, donations of clothing for our students and children, and a better understanding by the community of welfare problems. In addition, a great deal of respect within the community has been generated by the self-help concepts of our organization. As an example of this respect, the ADC Association and its self-help concept was mentioned in the application of the City of Eugene for All-American City, an award it won for the year 1970.

INFORMATIONAL BACKGROUND—A.D.C. ASSOCIATION OF LANE COUNTY; A.D.C. SCHOLARSHIP PROGRAM

I. Historical background

The Lane County A.D.C. Scholarship Program was conceived and designed around a kitchen table by a group of A.D.C. recipients. They presented it to the 1967 Oregon State Legislature and lobbied to ensure its passage.

The program was originally designed to receive token funding from the state. When passage of the bill setting it up was in danger for lack of funding, the A.D.C. group agreed instead, to specify that needed funds would be raised by the local A.D.C. association.

Because originally no state money was appropriated for staffing, the program was poorly administered until 1970 when some staff was added at the local level to try to provide services for the large growth in numbers of students.

The A.D.C. Scholarship covers costs for tuition and books only. The Lane County Welfare Commission has appointed an A.D.C. Scholarship Committee to approve scholarship applicants and administer funds. Membership on the Committee includes welfare recipients and representatives from the ministerial association, business community, labor organizations, and educational institutions.

Most students attend Lane Community College but approximately 6 per cent attend the University of Oregon.

II. Philosophy

The program operates on a philosophy that all people should have an opportunity for education regardless of financial status, test scores, professional evaluations, previous failures and past problems.

III. Case studies

These case studies of typical A.D.C. Scholarship students provide examples of some of the program successes:

Mr. M.—Age 25-30; wife and 2 children had nervous breakdown—not eligible for other programs one year training in Radio Broadcasting employed 1970 in California as a radio broadcaster.

Mr. C.—Age 33; wife and 2 children severely handicapped by polio—refused training by all other agencies and judged to be physically unemployable. Wife hospitalized for emotional problems. Two-year program in Technical Drafting. Employed 1971 as a draftsman for local construction firm.

Mrs. G.—Age 36; three children; divorced one-year Secretarial/Social Science course on welfare on Thursday, enrolled in school the following Monday. Employed 1970 by City of Eugene as a community development worker.

Mrs. M.—Age 29; children; divorced two-year Accounting Clerical course honor student—member Phi Theta Kappa honor society employed 1971—ten days after graduation by local restaurant.

IV. Growth and scope of program

During the 1967-68 school year 19 people attended school on an A.D.C. Scholarship. As knowledge of the program spread, the number of students increased so that during 1971-72 between 200 and 300 people are expected to take advantage of training opportunities.

The A.D.C. student population is comprised of divorced or widowed mothers with children, children in A.D.C. homes, unwed mothers, school dropouts, men refused by other programs, foster children and physically or mentally handicapped people.

Seventeen per cent of the students are children (under 21) from A.D.C. homes and the rest are adults ranging in age from the early twenties to the forties and fifties.

At present (1971-72) we have over 200 students at Lane Community College and 20 at the University of Oregon, our students continue to succeed. This is evidenced by their grades (2.5 average) and by their increasing involvement in the community at many levels.

V. Future of the program

The explosive growth in the numbers of A.D.C. scholarship students since 1967 has caused a funding and service crisis. There has not been adequate counseling, follow-up, or welfare servicing. Even in light of financial difficulties, A.D.C. Association members are continuing to raise funds and adjust the program to meet current needs. However, this adjustment does not include turning away eligible applicants for lack of funds. Our policy continues to be one of enrolling the student first and raising the money afterward. This is consistent with the distinguishing characteristic of the A.D.C. program which is its philosophy of concern for the worth and success of individuals. This differs greatly from the philosophies of other programs which, when implemented, appear to be more concerned about statistical information and showing results, often to the neglect of the individual's real interest.

As a part of this concern for our students, we are constantly on the alert for possible violations of Federal and State laws and regulations. Sometimes our information comes to us through our friends, thus, illustrating the importance of establishing firm contacts within, and beyond, the community.

In one case, we received information from an educational Financial Aids officer in California through a local friend, who told us that the Welfare Department was illegally deducting school expenses (NDEA loans, grants and scholarships) from regular assistance checks. We wrote a letter to the regional HEW office in Seattle to check this information, and their replies showed us that the Department was clearly in error.

Following are copies of the letters we received. We keep these in our files, along with all other correspondence to use at any time that there is a dispute over the validity of our statement or our actions. Then, we can produce Xerox copies of whatever we need, while retaining the originals for future use.

On issues such as this, where large groups of people are involved and legal rights are threatened, we make our information available to everyone concerned as quickly as possible.

Knowledge is protection against unnecessary distress. It is our obligation to provide an education regarding the students rights and privileges under the welfare system as well as encouraging them in an education toward self-sufficiency.

CONFIDENCE CLINIC

One of the most exciting programs we're beginning to establish in Oregon, is the Confidence Clinic Program, designed to increase the level of morale and feeling of self-worth among recipients so that they will be better able to take direction of their own lives. Although this intent of the contract itself is to prepare persons for eventual training and employment, the philosophy inherent in the Association is to make recipients aware of their full potential as human beings and to give them enough confidence to exercise that potential in whatever manner best fits their individual desires.

Programs have already been established in Medford, Klamath Falls, and Roseburg. Lane County is in the process of establishing one in Eugene. These programs vary somewhat in format, to allow for differences in regional resources and emphasis, but all the programs share the common goal of personal self-worth.

The Confidence Clinic has tremendous potential for expanding our thinking on welfare reform and rehabilitation, by creating a program that is multi-focus in nature, and that draws from the recipient population allowing recipients to become their own change agents, we are perhaps making an even more dynamic statement about the nature of professionalism and human service in this country.

We are saying, that the client is his own best resource and that paraprofessionals, as trained through active participation in our program, will be able to perform quality services to the community in areas that were formerly thought to be the exclusive province of the college educated.

With this program, we are possibly taking a critical step in answering the questions "How does a person get out of the welfare cycle?", and more important, "What can be done about the welfare problem?"

Our contract as follows :

AGREEMENT TO PURCHASE SERVICES

Whereas, Lane County ADC Association, Inc., hereinafter referred to as Association, is a nonprofit corporation of the State of Oregon, and

Whereas, the Children's Service Division, hereinafter referred to as the Division, desires to obtain services through a purchase of services agreement, from available funds,

Now, therefore, Association and Division agree as follows :

Association Agrees to:

1. Furnish the following services through the Confidence Clinic, for the purpose of providing pre-employment or pre-training services which will help the individual become better prepared for employment or training.

- a. Basic education
- b. GED training
- c. Grooming
- d. Job search techniques
- e. Individual and group counseling
- f. Referrals to Divorce Clinic
- g. Office training
- h. Speech
- i. Locate housing and child care in emergencies

2. Through the combined efforts of members of the Association to provide mutual encouragement and support to each individual referred to them for the above services (see No. 1).

3. Confer and help develop an individual plan for each individual referred by the staff of the Division.

4. Provide progress reports on each individual and other reports as may be required by the Division.

5. Provide reports which will demonstrate and document individual change in response to services received from the Association.

6. Provide for a periodic internal audit following established auditing procedures to insure accountability of expenditures and costs.

7. Abide by the applicable State and Federal statutes, the applicable rules and regulations of the Division, and the applicable rules and regulations of the U.S. Department of Health, Education, and Welfare.

Division agrees, through the Lane County Department, to:

1. Screen and refer AFDC recipients who appear to be in need of confidence building as part of their general rehabilitation, to the Association for the above services (see No. 1 a. through i.).

2. Encourage the participation of the individuals who have been referred, in the services of the Association.

3. Provide information to the Association which will help the Association in providing services to individuals.

4. Arrange and provide child care costs and training allowances in accordance with current Division policies.

5. Provide consultation and technical assistance to the Association through the staff of the Division and the Lane County Welfare Office.

6. Payment for services provided for individuals referred to the Association as follows:

a. Monthly payment of services for each individual—\$110.00.

b. Cost of service is based upon an average of 20 referrals each month for a period of service up to 90 days for each individual.

The parties mutually agree that:

1. Association shall act as an independent agency and Division shall be in no way associated with or otherwise connected with the actual performance of this

agreement on the part of the Association, nor shall this agreement in any way render the Division or its staff responsible or liable in any way for any act or omission of Association or its staff in such performance.

2. This agreement, each and every part, rights and duties, is not assignable.

3. Either party hereto may terminate this agreement by at least 90 days' written notice or it may be terminated by mutual consent, but, if not so terminated, it shall be in effect from-----day of-----, 197 , through the -----day of-----, 197 , and shall be automatically renewed each year on a year-to-year basis unless-----days' written notice is given to the other party expressing an intent that the contract shall not be automatically renewed.

Senator TALMADGE. The next witness is Mr. Michael B. Trister, Washington Research Project Action Council, accompanied by Nancy Duff Levy.

STATEMENT OF MICHAEL B. TRISTER, WASHINGTON RESEARCH PROJECT ACTION COUNCIL; ACCOMPANIED BY NANCY DUFF LEVY

Mr. TRISTER. Mr. Chairman, my name is Michael B. Trister, and I am testifying on behalf of the Washington Research Project Action Council. With me is Nancy Duff Levy, attorney, who has represented numerous welfare recipients and welfare client organizations throughout the country. The research project action council has participated with many other groups, some of whom you have heard from already, in developing and supporting the Harris welfare proposal, S. 2747. We believe the Harris proposal is a genuine step in the direction of welfare reform, that it offers a reasonable and a sensible structure for welfare reform, and that it deals with the essential issues of welfare reform forthrightly and in a manner which I think deserves the close attention of this committee.

As attorneys we would like to address ourselves today to some of the procedural problems, the problems which relate to the treatment that welfare recipients receive or would receive under H.R. 1, and to refer the committee to the manner in which the Harris bill attempts to deal with some of these aspects of H.R. 1.

The first point we would call the committee's attention to is the requirement in H.R. 1 that all recipients will be terminated automatically at the end of 2 years on the welfare rolls and will then have to go through all of the procedures and all of the paperwork to reapply.

So far as we are concerned this is just one of the many provisions in H.R. 1 which is designed to harass welfare recipients, to subject them to numerous requirements which have no purpose whatsoever. Since the welfare recipient under H.R. 1 would be eligible to reapply it certainly can't be aimed at getting them off the rolls for any legitimate reason. The only reason for making recipients reapply, it seems, is in the hopes that some of them will get lost in the shuffle and some of them will not know that they can reapply and some of them will be unable to go through the paperwork to deal with the bureaucracy and will be lost, as we say in the shuffle.

There is no other reason to create such a bureaucracy and to require people to just go through a needless procedure to reapply for welfare.

Senator HANSEN. May I interrupt, that is your conclusion, I guess, isn't it?

Mr. TRISTER. Quite clearly. We would refer you to the committee report from the House, which simply says that "We are doing this as an example of our desire to get people off the welfare rolls as a symbolic gesture," and I think the reference is in the committee report, and we appreciate the need to get people off the welfare rolls, and we are not encouraging people to stay on the welfare rolls for 2 years. But we think it is a symbolic gesture that simply creates more paperwork and serves no purpose whatsoever.

A second aspect which we would like to mention are the penalties and reporting requirements which the bill, which H.R. 1, sets up.

Under the bill, under H.R. 1, a recipient must report at the end of each quarter his or her income for that quarter. They must do this whether or not there has been any change in his income or whether that would have any effect on his or her grant.

Now existing law requires recipients to report changes when they would have an effect on the grant. We don't disagree with that provision whatsoever. What we disagree with is requiring recipients to file again quarterly reports and penalizing them in dollar amounts and finally terminating their grants if they do not file those reports when filing a report can give the welfare agency no new information at all, and may well indicate that the recipient was getting less money than they were entitled to. Even in that situation if a recipient failed to provide the report, that recipient would be penalized and we see no reason whatsoever for that kind of reporting requirement again.

The third procedural aspect of H.R. 1 which is not found in the language of the bill but is found in the House committee report refers to the simplified declaration system which, as the committee is aware, has been tested in virtually all of the States by now. Under this procedure welfare recipients go in and fill out a fairly detailed report concerning their financial situation, and on the basis of that report their eligibility is determined. If they are eligible they are immediately placed on the welfare rolls.

The experience under this system is that it saves an enormous amount of time on behalf of welfare officials, that it does not lead to an increase in fraud, and that there is a tremendous saving in terms of time and money on behalf of the welfare department.

Unfortunately, the House committee report clearly states that under H.R. 1 that procedure could no longer be used even on a test basis, and we see no reason again to implement procedures, in this case which would require investigations into every recipient before they are eligible, before they are determined to be eligible, instead of adopting a procedure which has been tested and proved to work with great success.

We would also like to call the committee's attention to several other provisions in H.R. 1 which we believe are arbitrary although they do not involve paperwork and that sort of problem. For example, under the bill if a recipient fails to apply for other benefits from other governmental programs within 30 days, the entire family is cut off. Now we understand the desire of the House committee to encourage recipients to explore other resources for their income in widow's benefits, whether they are veterans benefits, or social security benefits are available. Quite clearly the welfare recipients should apply for those, but where they do not we can see no reason for penalizing the entire family

particularly when it is not in regard to the amount of any benefits they may have received.

We think it is a much fairer procedure to simply say if benefits are available, and the recipient does not apply for them why not just reduce their grant by the amount of those benefits, but certainly don't terminate the entire family without any regard to the amount of those benefits.

Also we would like to mention the residence requirements. Now as this committee is well aware, I am sure, the Supreme Court on five separate occasions beginning in 1969 has struck down durational residency requirements for welfare. Nevertheless, H.R. 1 allows the States to impose a residency requirement with regard to the supplemental benefits under the H.R. 1 program. We are deeply concerned about Congress essentially just ignoring the Constitution and the Courts' pronouncements on this kind of matter where it is spoken so clearly and has shown absolutely no indication that it will be changed. The most recent decisions are only 2 weeks ago involving the States of New York and Connecticut.

There are other procedural rights in H.R. 1 that we think are being eroded tremendously and we would like to refer to those. The right to administrative hearing according to the Supreme Court must come before the benefits are terminated. This is a right which other recipients of government benefits have and the Supreme Court has said that the Constitution requires it.

Nevertheless, the committee report from the House would indicate that if a recipient does attempt to have such a prior hearing and ultimately loses the hearing they will be penalized for the time they were on welfare, while they were waiting for the hearing. We think this is an effort to deter recipients from seeking hearings which they are entitled to, and essentially to erode a constitutional right which the Supreme Court has said applies in these cases.

Similarly, the right to judicial review of administrative hearings under the welfare reform bill, H.R. 1, is significantly limited insofar as there is no review of questions of fact. We can see no reason for singling out welfare recipients administrative hearings from social security hearings and from all other administrative hearings in this system and simply saying for welfare recipients they get less of a right to judicial review.

Senator TALMADGE. Mr. Trister, I am sorry your time has expired. Your full statement will be inserted in the record. Are there any questions?

Senator FANNIN. Mr. Chairman, I would just like to know, are you an officer of the Washington Research Project Action Council, officer or official?

Mr. TRISTER. No, Senator, I am an attorney and appearing on behalf of the Action Council. I work for the Research Project—

Senator FANNIN. You work for them. Do they receive Federal funds?

Mr. TRISTER. No, Senator.

Senator FANNIN. What is the source of the funds?

Mr. TRISTER. Private funds.

Senator FANNIN. Sir?

Mr. TRISTER. Private funds.

Senator FANNIN. Private funds, foundations.

Mr. TRISTER. Not for the Action Council, no.

Senator FANNIN. Sir?

Mr. TRISTER. Not for the Action Council.

Senator FANNIN. Not for the Action Council. Are there foundation funds involved then in the money that is utilized to for instance, pay you and others who are working for the Washington Research Project Action Council?

Mr. TRISTER. I do not work for the Action Council, I work for the Washington Research Project on Non-Legislative and Non-Political Matters, entirely as an attorney and that is paid.

Senator FANNIN. I am just trying to find out what is the Washington Research Action Council, how many members do they have, what does it consist of?

Mr. TRISTER. It is not a membership organization itself, Senator.

Senator FANNIN. What is it? If we are having testimony from you as attorney for them, I would like to know who you represent.

Mr. TRISTER. We are an organization, a public interest organization, that has worked with welfare recipients and welfare recipient groups throughout the country in legal matters and nonlegal matters. We work on other issues relating to poverty and civil rights. We are not a membership organization. We attempt to represent the issues of the poor as they present them to us here in Washington.

Senator FANNIN. Well, I still don't know how you are funded other than you say you receive contributions, is that your statement?

Mr. TRISTER. Yes, sir.

Senator FANNIN. And that is the sole source of the funding of the Washington Research Project Action Council.

Mr. TRISTER. Yes, sir.

Senator FANNIN. Thank you.

Senator TALMADGE. Thank you very much.

Senator HARRIS. Mr. Chairman, I have a question or two. Nancy, did you have anything you wanted to add?

Mrs. LEVY. Well, no. We prepared the testimony together and we tried to emphasize what we thought were the rights provisions, especially as attorneys which we were particularly concerned about.

Senator HARRIS. It seems to me that we should want particularly to encourage the fair treatment under law for poor people, and that is what you are talking about insofar as the deficiencies of H.R. 1 are concerned, isn't that so?

Mrs. LEVY. Yes.

Senator HARRIS. To try to use the law. If society thinks there are some good reasons why it ought to tax itself with a welfare system either because we want to give charity to others and make ourselves feel better or because we think there is some self-interest involved or for other reasons, one would think we wouldn't try to demean people by making them have to humiliate themselves to get what we set up. That is why I think what you said is terribly important, that people ought to be encouraged to understand what their rights are and there ought to be clear provisions to litigate their rights. That is what our society is about. So I appreciate very much what you have said. I think that it is a major deficiency in H.R. 1, that we still want to

inflict charity on people and we want to have them take their caps off and shuffle a little bit to get it. I think it would be a lot better to stand up and be Americans. I think that is what you are talking about and so I appreciate what you are doing. I also appreciate what the Washington Research Action Council is doing.

May I just also say that I think it is really awful what the Congress did in regard to the tax-exempt laws. I opposed that at the time, and I think it is a shame that a lot of poor people and minorities and others now really have an awful time competing with corporations that can lobby and advertise on public issues as a business deduction, whereas others have a much more difficult time now that the new law has been passed. I am glad there are people like yourself and I think you have made some very important testimony here.

Senator TALMADGE. Thank you very much.

(The prepared statement of Mr. Trister follows:)

PREPARED STATEMENT OF MICHAEL B. TRISTER ON BEHALF OF WASHINGTON
RESEARCH PROJECT ACTION COUNCIL

Mr. Chairman, my name is Michael B. Trister, and I am testifying on behalf of the Washington Research Project Action Council, which has participated with numerous other organizations in developing and supporting S. 2747, the welfare reform bill introduced by Senator Harris. We believe that S. 2747 offers a genuine step in the direction of a guaranteed adequate income for all Americans, financed and administered by the federal government. It eliminates the arbitrary categories and distinctions which characterize our present welfare system, and it provides humane and decent incentives to encourage recipients to work. Finally, the Harris proposal provides a sound and fair structure for the administration of the welfare program. It is on this aspect of the bill that we would like to focus our attention today.

As attorneys for welfare recipients and recipient organizations throughout the country, we are especially concerned with the *treatment* received by recipients within the welfare system and we are aware of the role of arbitrary and harsh rules and procedures in defeating the beneficial purposes of the welfare program itself.

Title IV of H.R. 1, as passed by the House, is filled with numerous procedural obstacles, whose purpose can only be to harass welfare recipients and to insure that many genuinely needy persons are lost in a maze of needless bureaucracy and paper work. Recipients, for example, are automatically terminated and must reapply every two years, whether or not their conditions have changed in the slightest. The Report of the House Committee on Ways and Means states that this provision demonstrates Congress' commitment to removing recipients from the rolls in as short a period as possible. HEW has argued, on the other hand, that it is necessary to obtain current data concerning the causes of poverty. It is not clear, however, how either of these purposes would be served, since recipients can reapply immediately, and the same data can be obtained without requiring a new application. Rather, the requirement must be designed with the hope that needy individuals will not reapply after they are terminated. If many do, of course, an enormous amount of needless administration will have been created. The provisions of the Harris bill, which eliminate this requirement, should be adopted.

An equally unnecessary procedure is outlined in the statement of the House Committee report that the simplified declaration system for determining eligibility, which is now being tested in most of the states, can no longer be used. Under this procedure, welfare recipients, like middleclass taxpayers, social security recipients, and many other beneficiaries of government programs, become eligible immediately after filling out a detailed statement of their financial condition. There is no investigation into every recipient's private life and no long delay before she receives assistance. All available studies of the experiment have found that cases of fraud have not increased and that there are *substantial savings* in staff time and other administrative expenses. Moreover, the simplified eligibility procedure frees welfare caseworkers for the more important social

work tasks for which they are trained. The Harris bill would apply the declaration system to all recipients.

In spite of the burdensome eligibility process and automatic termination after two years, H.R. 1 also requires a family to report its earnings and expenses within thirty days after the end of each quarter that it receives assistance. A family which fails to make such a report will be terminated until the report is received, and, if the failure was willful, it will be liable for a penalty of \$25 for the first failure, \$50 for the second, and \$100 thereafter. The report must be filed, and the penalties attached, even where there has been no change in the family's status which would affect its assistance payment (or where the unreported change was in its own favor). (The Ribicoff bill retains this requirement, but allows the Secretary of Health, Education and Welfare to fix the penalties.) Under current law, recipients are required to report all changes in their status immediately after they occur, but they do not have to go through the burdensome procedures, subject to stiff and unfair penalties, of filing otherwise useless reports. Moreover, under H.R. 1 it is possible that many grants will be terminated because the reports are lost in the mail or are not properly recorded by welfare officials.

The administrative scheme proposed in H.R. 1 is more than burdensome and wasteful. In several important respects, it subjects recipients to arbitrary and harsh conditions which have no place in a system based on due process of law. For example, the payment to which a family is entitled will be based on its estimated earnings for the current calendar quarter (discounted by its excess earnings during the previous three quarters.) If, for any reason, the estimated earnings fall short of actual earnings, then the bill provides that the family's next payment will be adjusted downward to make up for the previous overpayment.

This adjustment apparently will be made regardless of whether the family or any individual member was responsible for the inaccurate estimate *and* regardless of whether the reduced grant will meet the family's current need. By contrast, under AFDC law, overpayments may be taken from current grants only if the family has the excess funds available to meet current needs, unless the overpayment resulted from a wrongful withholding of information. It is, of course, arbitrary and unduly harsh to punish a family because of administrative errors or changes in their income over which they have no control. S. 2747 allows recovery of overpayments only when the recipient is at fault and the funds are still available.

If a recipient fails within thirty days to apply for benefits available from other sources, his or her *entire family* is made ineligible, regardless of the amount of benefits which they might have received. We have no difficulty with requiring recipients to exhaust alternative resources, but we cannot understand why the entire family must suffer or why their grant is not simply reduced by the amount of outside benefits which are available to them.

H.R. 1 also allows the states to impose a one-year durational residence requirement as a condition for receiving supplemental benefits. As this Committee is certainly aware, the Supreme Court has struck down as unconstitutional identical requirements for receiving welfare benefits on at least five different occasions since 1969, including two cases decided only two weeks ago by a unanimous Court. We hope this Committee will not approve such open and flagrant defiance of the Constitution and the Court.

Fundamental procedural rights are also severely curtailed under H.R. 1 in 1970, the United States Supreme Court ruled that welfare recipients are entitled to a hearing *before* their public assistance grants are terminated; and regulations issued by HEW have extended this right to include reductions in benefit levels under certain circumstances. The House Committee report attempts to deter recipients from pursuing these rights by providing that recipients who ask for a hearing before termination or reduction will be liable for any benefits received during the hearing process if their appeal is ultimately unsuccessful. Also, judicial review of questions of fact decided in such hearings is expressly denied by H.R. 1. Numerous other beneficiaries of government programs, including holders of government contracts and school systems receiving federal financial assistance, are fully protected in both of these areas. There is no legitimate reason for ignoring these rights where welfare recipients are concerned.

Finally, H.R. 1 would allow the Department of Health, Education and Welfare to continue to operate the welfare program beyond the scrutiny of Congress and the public in general. By its passage of the Administrative Procedure Act, Con-

gress has recognized the benefits obtained from requiring administrative agencies to follow public rulemaking procedures before making any fundamental policy or regulatory decisions. We therefore urge the adoption of the provision in the Harris bill which subjects HEW's procedures under the new program to the strictness of the Administrative Procedure Act.

As troubling as the burdensome and arbitrary rules imposed by H.R. 1 are the numerous ways in which the bill seeks to control the conduct of recipients through coercive and ill-conceived measures. Thus, the bill attempts to force parents to meet their obligations to support their families by making the failure to support a federal crime. This imposes a different standard of parental support and penalties for failure upon poor families than upon others, with the federal government usurping functions normally handled by state laws and courts.

In addition, H.R. 1 imposes a lien on any future federal entitlements which may be due an alleged deserting parent, including future welfare benefits or old age insurance benefits, in an attempt to recover alleged support payments due. This is done without benefit of a court order or hearing to establish either desertion or the amount of support owed. Such provisions not only discriminate against the poor, they also violate basic concepts of due process.

Similarly, it is counterproductive to reduce a family's assistance because of the income of a stepparent without regard to whether he has a legal duty of support for his wife's family under state law or whether he is also contributing to the support of his own children. Rather than forcing the stepparent to support his stepchildren, the requirement will more likely discourage mothers from remarrying and thereby reducing the family's benefits, and will encourage current stepparents to leave home so the mother and children can receive higher benefits. This can only result in an increased rather than decreased need for welfare benefits.

Finally, one of the most pernicious elements of control in H.R. 1 is the treatment afforded family members whom a caseworker determines are in need of vocational rehabilitation or who are disabled due to drug or alcohol abuse. Such persons are eligible for benefits only so long as they undergo approved treatment for their conditions. These are clearly the kinds of provisions which can be disabused to control recipients who are most in need of help. Yet H.R. 1 contains no standards for making such determinations.

In conclusion, Mr. Chairman, we believe that each of these issues is so important to welfare reform that we cannot support H.R. 1 or any other bill unless they are corrected.

Senator TALMADGE. The next witness is Mr. William F. Biggs, executive director, Salt Lake area community action program, Salt Lake City, Utah.

Senator BENNETT.

Senator BENNETT. Mr. Chairman, I was happy to welcome Mr. Biggs and his companions to my office this morning and we already have had a very interesting discussion of the legislation and the problems, and I am happy that he is here as a witness to tell us how this proposed law looks, from the point of view of the people of Utah. He has given me some information with respect to the potential effects of the law on Utah's present system which I did not have before.

Mr. Biggs, would you introduce the other two people with you.

STATEMENT OF WILLIAM F. BIGGS, EXECUTICE DIRECTOR, SALT LAKE AREA COMMUNITY ACTION PROGRAM, SALT LAKE CITY, UTAH, ACCOMPANIED BY MRS. BONNIE HARTLEY, VICE PRESIDENT, UTAH WELFARE RIGHTS; AND ANDREW GALLEGOS, COALITION OF SPANISH SPEAKING ORGANIZATIONS OF UTAH

Mr. Biggs. I would like to introduce Andy Gallegos representing the Utah Coalition of Spanish Speaking Organizations, and Bonnie Hartley representing Utah Welfare Rights.

Senator TALMADGE. You may proceed.

Mr. BIGGS. Thank you, Senator. I greatly appreciate the opportunity to appear before you today representing Utah CAP Director's Association, the Utah Coalition of Spanish-Speaking Organizations in the State of Utah, Utah Welfare Rights Organization. In addition to those I named I am also representing the Utah Association of Neighborhood Councils, and the executive board of the Utah Council of Churches. We firmly believe in the need for welfare reform, firmly support the need to provide incentives to those on welfare, assistance to the working poor, and we support the basic provisions in H.R. 1 for the elderly poor and disabled.

However, the family assistance portion of H.R. 1 would, we believe, prove a disaster upon implementation. I urge you to consider with me the effects of this portion of the bill upon the individuals and institutions of Utah. Since Utah is in the middle of States in this country in terms of levels of payments, the situation is especially relevant for comparison of present and proposed assistance levels under H.R. 1.

The State of Utah recently approved an increase in assistance grants from 70 percent of basic minimum need to 75 percent of needs. Under the 75-percent-of-need figure we will be providing for a family of four a basic grant of \$2,880 annually. In addition each family is eligible for a food stamp bonus of \$516 for a total annual benefit of \$3,396 per year.

In contrast, H.R. 1 provides for an income floor of only \$2,400 for a family of four and eliminates the food stamp program. Assuming no State support and the bill provides no incentive for the State to do so, this would mean a cut in benefit levels for a family of four of \$996 or 28 percent. But even worse is the effect on the larger family since the payment level under H.R. 1 is not based on need and provides no additional assistance to families over eight in size. The eligibility and benefit sections of this legislation make no provisions for families consisting of more than eight members. This evidently intended omission could effectively reduce the status of many beneficiary families from certain Indian groups in Utah as well as other large families, to one of degradation and starvation. Specifically, as it applies to Utah, this section of the legislation would adversely affect 4,562 individuals now receiving assistance. For a family of 10 on AFDC in Utah, the level of assistance would be cut from \$6,504 to \$3,600.

Senator HARRIS. For a family of how many?

Mr. BIGGS. Of 10. With the cuts of medicaid also contained in the bill the cut would reach close to 50 percent. Thus in Utah we would be faced with cuts of from 28 percent up to 60 percent from an assistance level which only meets 75 percent of minimum need as set by the State legislature.

What would happen? Private agencies including the Mormon Church welfare program could not conceivably take up the slack. For the larger family a lack of housing or starvation would be a reality. How could a family of 10 support itself on \$3,600 a year. Further, how can a payment of only \$2,400 for a family of four be justified when in the same bill \$2,400 is provided for an elderly family of two.

Inadequate attention has also been given to the strain that this bill would put on the State and local government as well as private agencies.

The pressure of families needing to provide for their children added to that of humane concerns of Utah citizens would pressure State government to provide additional assistance. However, the legislative and executive branches would have difficulty supporting with State funds a now totally federalized program with no incentives to do so.

If they did provide assistance, additional assistance, would be in the form of a check to the Federal Government.

The second most serious defect in the bill, after the low-assistance level, is the punitive and arbitrary requirements related to work. The assumption is made throughout H.R. 1 that persons receiving assistance are unwilling to work and that this is the major problem with the present program. This we simply find to be not true. First of all, many of those on assistance are not able to work because of the necessity of taking care of their young children. Second and most important jobs are simply not available. Less than 40 percent of those graduating from WIN training actually receive a job because of the existing high unemployment rate of 6.1 percent in Utah. The Salt Lake Community Action Agency—

Senator HARRIS. Less than what percent?

Mr. BIGGS. On WIN, only 40 percent of those graduating actually achieve a job.

Senator HARRIS. Find jobs.

Mr. BIGGS. The Salt Lake community action program normally receives at least 20 job applications from persons on welfare for every aide position opened in spite of the fact that the beginning salary level is only \$300 per month. Under the much heralded emergency employment act only about 5 percent of those hired in Utah and nationally were welfare recipients, not because they did not apply but because of high qualifications such as college education or an electrician, the number of people, persons seeking positions and because of what we believe to be simply prejudice against persons on assistance. While everyone talks about lazy welfare recipients no one, except a few businessmen, appear willing to offer welfare recipients a job.

The \$800 million proposed for public services jobs under H.R. 1 represents a positive step forward, in our opinion, but is inadequate. This would provide only approximately 800 positions in Utah. I can assure you that we have both enough welfare recipients and disadvantaged people in Utah, and enough needed productive jobs for them to perform to urge at least a doubling of this program during the first year.

We are also opposed to the provision that as of 1974, all mothers without children under 3 years of age must, without exception, register for work or take training, regardless of the quality of child care available, or the children's need for a parent in the home. I certainly would not want my wife to work before our children are in the first grade, or 6 years old, and furthermore I would want my wife or myself to be at home with the children during the summer. Especially, young children need the attention of their parents. Furthermore, in many cases, the child care costs will exceed the income gained from work.

The incentive provisions of H.R. 1 with one exception represent a tremendous step forward and are vitally needed. The bill's provision which basically allows for a person on family assistance to keep the first \$720 of earned income plus one-third of the remainder is strongly

supported by Utah Welfare Rights and the other groups represented before you today. What we take exception to is recipients on assistance will be required to accept jobs paying as low as \$1.20 per hour. This provision will only perpetuate low-paying jobs presently not covered by the Federal minimum wage.

Over the past 6 years a body of laws have been developed providing a number of basic rights to recipient on assistance which has enabled recipients to enjoy some of the same basic rights as others.

Senator TALMADGE. I am sorry, Mr. Biggs, your time has expired. Your entire statement will be inserted in the record.

Mr. BIGGS. Thank you.

Senator TALMADGE. Any questions?

Senator HARRIS. Mr. Gallegos, have you got any additional comments that you want to make?

Mr. GALLEGOS. Of course, we have input into the statement Mr. Biggs has been reading. We would hope this committee in considering the new Employment Emergency Act that a minimum of 50 percent of those jobs be allocated to the disadvantaged people. I might add that in our State the Governor had wanted as a goal, at least because of the Department of Labor regulations, however as a goal for two-thirds of the jobs that we received to be allocated for the disadvantaged. Unfortunately, we have only 18 percent of those that have been filled to the disadvantaged because of the high requirements.

Senator HARRIS. Mrs. Hartley, did you have anything else you wanted to add?

Mrs. HARTLEY. No. I think the mothers who were here before spoke so well I certainly could not improve upon that.

Senator HARRIS. Well, I really appreciate your testimony. What you demonstrated again, despite the misconceptions of a lot of well-meaning progressive people in the country, is that H.R. 1 is not welfare reform. It has got some awfully punitive and regressive factors involved in it and if that is going to pass as welfare reform, I think we are in lots of trouble.

Senator BENNETT. Mr. Chairman, I would like to add my thanks to these folks who have come all the way from Salt Lake and I hope you have enjoyed your experience in participating in the process of legislation today, and the specific suggestions which are contained in that part of your statement that you did not read will be carefully analyzed by the staff and looked at by the members of the committee.

Senator TALMADGE. Thank you very much, we appreciate your appearing.

(The prepared statement and attachments of Mr. Biggs follow. Hearing continues on p. 2370.)

PREPARED STATEMENT OF WILLIAM F. BIGGS, EXECUTIVE DIRECTOR, COMMUNITY ACTION PROGRAM, SALT LAKE CITY, UTAH¹

INTRODUCTION

Mr. Chairman, Honorable members of Congress, distinguished visitors. I greatly appreciate the opportunity to appear before you today to express the

¹ Representing the Utah CAP Director's Association, the Utah Association of Neighborhood Councils, the Union of the Poor, the Coalition of Spanish-Speaking Organizations (COSSO-Utah) Utah Welfare Rights, Social Action Committee and the Executive Board of the Utah Council of Churches, and Church and Society Committee of Cooperating Christian Churches of Utah. The denominations represented are United Presbyterian, United Methodist, United Church of Christ, United Christian Church—Disciples.

concerns regarding H.R. 1 of a wide range of organizations in Utah, including the Utah CAP Director's Association, the Utah Coalition of Spanish-Speaking Organizations in the State of Utah, Utah Welfare Rights Organization, the Social Action Committee and the Executive Committee of the Board of the Utah Council of Churches, and the Church and Society Committee of the Cooperating Christian Churches of Utah. The numerous Utah organizations which I represent here today firmly believe in the need for welfare reform, firmly support the need to provide incentives to those on welfare, assistance to the working poor, and firmly support the provisions in H.R. 1 for the elderly poor and disabled. However, the family assistance portion of H.R. 1 would, we believe, prove a disaster upon implementation. I urge you to consider with me the effects of this portion of the bill upon the individuals and institutions of Utah. Many programs look good in overall concept; it is only when we examine their actual effect in the various states of the Union that their true nature can be judged.

ASSISTANCE PAYMENT LEVELS

The situation in Utah is especially relevant for a comparison of present and proposed assistance levels under H.R. 1 since Utah is in the middle of states in this country in terms of level of payments. An average, rather than an extreme situation, is therefore represented.

The State of Utah recently approved an increase in assistance grants from 70% of basic minimum need to 75% of needs which will take effect in the latter part of this year, barring a dip in the economy and a subsequent increase in welfare recipients.² using the 75% of need figure, Utah will be providing for a family of four a basic grant of \$240 per month, or \$2,880 annually. In addition, each family is eligible for a food stamp bonus of \$43 per month or \$516 annually, for a total annual benefit of \$3,396 per year.³ For a family of ten, and we have a number of large families in Utah, the total annual benefits including both grant and food stamp bonuses would be \$6,504.

In contrast, H.R. 1 provides for Federal administration of assistance programs with a guaranteed income floor of only \$2,400 for a family of four and eliminates the food stamp program for those receiving assistance.⁴ Assuming no state support, and the bill provides no incentive for the state to do so, would mean a cut in benefit levels for a family of four from \$3,396 to \$2,400. This is a reduction of \$996, or 29%. But, even worse is the effect on the larger family since the payment level under H.R. 1 is not based on need and provides no additional assistance to families over eight in size. The eligibility and benefit sections of this legislation *make no provisions* for families consisting of more than eight members. This evidently intended omission could effectively reduce the status of many beneficiary families from certain Indian groups and religious denominations, as well as all other large families, to one of degradation and starvation. Specifically, as it applies to Utah, this section of the legislation would adversely affect 4,562 individuals now receiving assistance. For a family of ten on AFDC in Utah the level of assistance would be cut from \$6,504 to \$3,600 under H.R. 1. This is a cut of \$2,904, or 44%. With the cuts in Medicaid also contained in the Bill, the cut would reach close to 50%. (See attached chart for a comparison of assistance levels by household size, page 7a.)

Thus, in Utah, we would be faced with cuts of from 29% to 60% from an assistance level which only meets 75% of need. What would happen? Private agencies, including the Mormon Church Welfare Program, could not conceivably take up the slack. For the larger family starvation would be a reality. Can you imagine a family of ten supporting itself on \$3,600 a year? The 43,860 present recipients of AFDC in Utah would face a situation of total frustration. How

² The projected payment level figure of 75% of need was used in order to more adequately reflect the effect of H.R. 1 at its projected time of implementation in 1973.

³ The assumption is made that everyone will take advantage of the new food stamp program at the full level provided for. On the other hand, none of the various income exemptions such as medical and housing costs over 30% of income are taken, so, in fact, for some families the food stamp bonus would be greater.

⁴ The incentive bonus of \$360, which would be provided under H.R. 1 for those engaged in training, as well as existing bonuses under the present WIN program, are not included since the number of persons who would actually receive the \$360 incentive bonus under H.R. 1 is difficult to project, and would be offset, in part, by costs involved in taking training, such as meals away from home, etc.

many people would leave their family or escape through other means when faced with an inability to provide food or shelter for their children?

Further, how can a level of payment of only \$2,400 for a family of four be justified when in the same bill \$2,400 is provided for an elderly or disabled family of two, which is described as a minimum level. Is a child worth only half as much as a senior citizen? One commentator accurately remarked that H.R. 1 is the natural consequence of a Bill in which those most affected, children, didn't have a lobby.

H.R. 1 eliminates the provisions for immediate adjustment of the recipient's situation when a situation changes. Adjustments can only be made on a three month basis. Thus, an employed person suddenly terminated from a low-paying job would have to be unemployed for many months to be eligible for assistance, rather than the current thirty days. If the person has not been able to build up any equity and is unable to get another job, what happens to the family? What happens to the family whose breadwinner dies if the woman is unable to work or to get work? What about rent or house payments? I think it doesn't take too much thought before one begins to realize what would be the impact if a job were lost and three months had to pass before the family could become eligible for assistance, particularly since the job could be one that would not qualify the worker to receive unemployment compensation.

Inadequate attention has been given to the strains that this Bill would put on the state and local government, as well as private agencies. One of the needs is to support local governmental institutions and reduce the division occurring in our society. This bill would have the opposite affect.

Assuming a chaotic situation did not exist before the state legislative session, chaos would erupt then. The pressure of families needing to provide for their children, added to that of the human concerns of Utah citizens would pressure the legislature to maintain present levels; however, the legislative and executive branches would have difficulty supporting with state funds a now totally Federalized program with no incentives to do so. To supplement the inadequate assistance provided under H.R. 1, the state would have to actually give the money to the Federal government unless the state was willing to provide for all administrative costs. Furthermore, if they did so, there would not be any reduction in state expenditure, which the populace has been led to believe would happen with passage of H.R. 1. (See attached chart, page 7b). The social and governmental system in Utah, like in other states, is too fragile to be subject to such cross-pressures without possible serious consequence.

H.R. 1 has been sold as providing "a basic floor" and equalizing payments among the states. In fact, in Utah, as in 45 other states, what would be presented is not a floor but a ceiling, and the equalization effect would be through reducing and not elevating present assistance levels, which are, in Utah and most states, below the minimum needed for sustenance. The result would be not only untold hardships and perhaps even starvation for many families, but an intolerable burden on already overtaxed local government and private agencies. A basic floor, at least equal to that provided the elderly and disabled and close to the assistance level provided by Utah and most States with the food stamp bonus is needed. Additional support must be provided to larger families. This would mean then, a level of at least \$2,400 for a family of two, \$3,400 for a family of four, plus \$500 for each additional children. A provision that assistance payments will not be lowered or incentives for states to maintain existing levels should be included. Anything less than this would mean not welfare reform but simply punitive action against those with no voice—children.

What would this cost? According to the report of the Senate Finance Committee staff, the total increase for payments to families under H.R. 1 would be only 1.4 billion which would be almost totally offset by reduction of the food stamp program. The actual additional cost projected primarily relates to increased services and increases in payments to the aged, blind and disabled. The minimal level of assistance we project as needed would represent an increased cost. However, much, if not most of this cost would be simply an assumption by the Federal government of existing state expenditures. Again, we come to a question of priorities and whether we are seriously concerned with achieving welfare reform and making progress toward the goal of eliminating poverty or simply enforcing additional punitive measures against the poor.

COMPARISON OF ASSISTANCE SUPPORT

Family size	Projected Utah support levels annually			Projected H.R. 1 support levels annually	
	Utah AFDC 75 percent of need budget	Food stamps	Total	H.R. 1	Difference
	(1)	(2)		(3)	(4)
1.....	\$1,356	\$144	\$1,500	0	0
2.....	1,824	288	2,112	\$1,600	-\$512
3.....	2,412	432	2,844	2,000	-844
4.....	2,880	516	3,396	2,400	-996
5.....	3,660	528	4,188	2,800	-1,388
6.....	4,320	612	4,932	3,200	-1,732
7.....	4,632	684	5,316	3,400	-1,916
8.....	4,956	756	5,712	3,600	-2,112
9.....	5,268	840	6,108	3,600	-2,508
10.....	5,580	924	6,504	3,600	-2,904
11.....	5,892	1,008	6,900	3,600	-3,300
12.....	6,216	1,092	7,308	3,600	-3,608
13.....	6,528	1,176	7,704	3,600	-4,104
14.....	6,840	1,260	8,100	3,600	-4,500
15.....	7,152	1,452	8,604	3,600	-5,004
16.....	7,476	1,536	9,012	3,600	-5,412

(1) The Utah AFDC 75% of need budget figures will not probably become effective until the latter part of 1972. This figure is used in order to more accurately reflect the effect of H.R. 1 at its projected time of implementation in 1973.

(2) The dollar amount indicated as income was derived by using the grant assistance amount as adjusted net income. In no case would the adjusted net income exceed the amount indicated, however, it would in all possibility be lower than the figures used, and would, therefore, generate more food stamp bonus than is indicated. The assumption is made that all eligible families would utilize the maximum allowable food stamp purchases.

(3) The incentive bonus of \$360, which would be provided under H.R. 1 for those engaged in training as well as existing bonuses under the present WIN program, are not included since the number of persons who would actually receive the \$360 incentive bonus under H.R. 1 is difficult to project, and would be offset, at least in part, by costs involved in taking training, such as meals away from home, etc.

(4) The one family household is presently provided for mainly under State General Assistance. Presumably this would continue under H.R. 1 although additional members previously provided for under AFDC might have to be picked up by the state.

The column labeled "Difference" is based on the above mentioned assumptions.

COST BY FAMILY SIZE FOR STATE OF UTAH TO MAINTAIN PRESENT ASSISTANCE LEVELS IN COMPARISON TO PRESENT STATE COSTS

Family size	Average Utah share of AFDC assistance	Difference between assistance levels under H.R. 1	Savings or cost to State to maintain 75 percent of need level
1.....	\$398	0	0
2.....	536	-\$512	1+\$24
3.....	709	-844	2-135
4.....	846	-996	2-150
5.....	1,076	-1,388	2-312
6.....	1,270	-1,732	2-462
7.....	1,361	-1,916	2-555
8.....	1,457	-2,112	2-655
9.....	1,548	-2,508	2-960
10.....	1,640	-2,904	2-1,264
11.....	1,732	-3,300	2-1,568
12.....	1,827	-3,608	2-1,781
13.....	1,919	-4,104	2-2,185
14.....	2,010	-4,500	2-2,490
15.....	2,102	-5,004	2-2,902
16.....	2,197	-5,412	2-3,215

¹ Reflects savings to the State of Utah if under H.R. 1 75 percent level was maintained.

² Reflects additional cost to the State of Utah beyond that presently spent to maintain 75 percent of need support levels if H.R. 1 becomes law.

UTAH WELFARE STATISTICS

Average number of persons in the State of Utah receiving public assistance is 57,639. This includes all categories of assistance.

The number of people by type of assistance is as follows:

Old age assistance-----	4, 506
Aid to families with dependent children-----	43, 864
Aid to the blind-----	231
Aid to the disabled-----	6, 282
General assistance-----	1, 018
Child care-----	1, 738

As of June, 1971, Utah's assistance levels as compared to the other 50 states:

OAA—Utah ranks 37th out of 50;
 AFDC—Utah ranks 23rd out of 50;
 AB—Utah ranks 14th out of 50;
 AD—Utah ranks 29th out of 50;
 GA—Utah ranks 12th out of 50.

96.6 percent of Utah families on public assistance have eight or less family members. The following is a percentage list by family size.

	<i>Percent</i>
0 -----	.6
1 -----	28.2
2 -----	22.4
3 -----	17.7
4 -----	12.5
5 -----	8.2
6 -----	4.7
7 -----	1.8
8 -----	.5
9 through 16-----	3.4

WORK PROVISIONS

The second most serious defect in the Bill, after the low assistance level, is the punitive and arbitrary requirements related to work. The assumption is made throughout H.R.-1 that persons receiving assistance are unwilling to work and that this is the major problem with the present program. This we simply find to be not true. First of all, many of those on assistance are not able to work because of the necessity of taking care of their young children. Second and most important, jobs are simply not available. Less than 40% of those graduating from WIN training actually receive a job because of the existing high unemployment rate of 6.1% in Utah. The Salt Lake Community Action Agency normally receives at least 20 job applications from persons on welfare for every aide position opened in spite of the fact that the beginning salary level is only \$300 per month. Also, unlike most other public or private agencies supported by the Federal government, Community Action Program agencies have made a practice of providing an opportunity to welfare recipients by offering jobs to them. Uniformly, our experience has been very positive. The Federal government and local governmental agencies have not shown a willingness to provide jobs to those receiving assistance. Under the much heralded Emergency Employment Act (PEP) Public Employment Program, only 5% of those hired in Utah and nationally were welfare recipients, not because they didn't apply, but because of high qualifications (college degree or special skills such as electrician), the number of persons seeking positions, and what we believe to be simply prejudice against persons on assistance. While everyone talks about lazy welfare recipients, no one, except a few businessmen, appear willing to offer welfare recipients a decent job.

The \$800 million proposed for public services jobs under H.R. 1 represents a positive step forward in our opinion, but is inadequate. This would provide only approximately 800 positions in Utah. I can assure you that we have both enough welfare recipients and advantaged people in Utah, and enough needed productive jobs for them to perform to urge at least a doubling of this program during the first year.

In view of the lack of jobs for those presently on welfare, and the need for many mothers to provide love and attention to young children, we are opposed

to the provision that as of 1974, all mothers without children under three years of age must, without exception, register for work or take training, regardless of the quality of child care available, or the children's need for a parent in the home. I certainly would not want my wife to work before our children are in the 1st grade, or six years old, and furthermore I would want my wife or myself to be at home with the children during the summer. Especially young children need the attention of their parents. Furthermore, in many cases, the child care costs will exceed the income gained from work.

H.R. 1, in its origin, seemed to reflect a sincere desire on the part of our selected officials to provide an income guarantee to provide our disadvantaged citizens with a means of dignified survival, but so many punitive measures have been inserted into the legislation that, along with the absurdly low guaranteed income, H.R. 1 now takes on the character of a Bill to use minimal income payments to the poor as a means of control and coercion with respect to employment, child rearing, and general behavior. For example, the \$2,400 annual income level for a family of four, often referred to as a "guaranteed income", can be reduced to \$1,600 if any member of that family, presumed to be employable, refuses work, training, rehabilitation or drug rejection. Therefore, the true "guaranteed income" is actually lower than present assistance payments (plus Food Stamp subsidy) in any state of the Union.

Assuming that jobs are, or will be available, I am sure we are all agreed that able-bodied people should work rather than be supported by welfare, but should children and other non-employable family members be punished by starvation or malnutrition for the transgressions of another family member? Does such punishment contribute to the productivity and independence of the next generation?

INCENTIVES

The incentives provisions of H.R. 1 with one exception represent a tremendous step forward and are vitally needed. The Bill's provision which basically allows for a person on family assistance to keep the first \$720 of earned income plus one-third of the remainder is strongly supported by Utah Welfare Rights and the other groups represented before you today. The existing welfare provision which basically eliminates a dollar for every dollar earned despite the costs of working helps to perpetuate welfare and prevents parents from developing an income adequate to support their families through securing part-time or low-paying jobs. In addition, we support the retention in H.R. 1 of the \$30 per month incentive for those taking training as vital to compensate for work related expenses, such as food, clothing, and incidental expenses related to work.

Perhaps even more important is the support for the so-called "working poor" in low-paying positions. Not only is the support provided for in H.R. 1 desperately needed to provide a basic level of support to enable the working poor to adequately support their families, but to help provide a cushion between jobs.

The one element in the incentive provision that we take exception to is the provision that recipients of assistance may be required to accept jobs paying as low as \$1.20 per hour. This provision would not only help perpetuate low-paying jobs presently not covered by the Federal minimum wage, but could inhibit the securing of appropriate job development and training which could lead to securing of jobs providing sufficient pay as to make Federal assistance no longer necessary.

ADMINISTRATION AND RIGHTS OF RECIPIENTS

Administration of the program is apparently control oriented, and effectively eliminates rights of beneficiaries built into the original Social Security Act and expanded by court and administrative rulings.

The division of administrative responsibility for this section among three Federal agencies would probably result in a nightmarish confusion as to agency responsibility, with families being shifted from agency to agency as their status changed with respect to age, employability or age of dependent children with resultant delays in benefits, confusion of the beneficiaries and exorbitant administrative costs. Separation of eligibility determination from services delivery responsibility should be a protection for the beneficiary if provided within one administering agency, but eligibility determination by the Department of Health, Education and Welfare (Sec. 2111), assignment of responsibility to the Department of Labor and subsequent redetermination of benefits by the Department of Labor (Sec. 2151) would be an invitation to confusion and delay.

A more cumbersome system would be hard to conceive. Every quarter a complete statement of income and assets must be filed by the recipient with evidence substantiating the figures. Further, every two years, in spite of the above requirements, the recipient must reapply for welfare assistance. No guarantee is provided that the Federal government will provide the necessary aid to recipients to meet these requirements, and there is no provision to ensure that recipients are, in fact, adequately informed ahead of time. In typical bureaucratic fashion, these requirements are to be satisfied solely through punitive measures. Further, if there is a delay in processing the amount of paperwork, the recipient will simply go without as there is no adequate provision to meet emergency needs or built in recourse for the recipient.

The Bill does not provide for (1) speedy processing of application forms; (2) adequate means to meet emergency needs, especially of the larger family; (3) an adequate means for coordination between the three agencies involved so families do not get lost in the administrative shuffle.

As the Utah Board of Family Services has stated in the attached letter, "the provision allowing the payment of a maximum \$100 on an emergency basis by local administrators is totally inconsistent to the basic needs of certain size families (and will) undoubtedly create severe hardships for many applicants." This maximum, along with the provision that the information contained in applications must be substantiated by the furnishing of evidence (no longer processed on the basis of an individual's declaration), along with the split in responsibilities among three agencies with resulting delays as clients are transferred from one to the other, and along with the lack of any provision for immediate adjustment with a change in circumstances, would establish a totally inflexible system with no ability to relate to the actual needs of families as they develop and before total disintegration of the family as a productive unit takes place. A dollar of assistance when needed is worth five dollars after the damage has occurred. This principle is as true in this area as in medicine.

Over the past six years, a body of laws based on court and legislative decisions have been developed providing a number of basic rights to recipients of assistance. Not only have these laws enabled recipients to enjoy the same basic rights as others, but, at least in Utah, these laws have helped develop a higher level of trust, understanding, and confidence between the State Division of Family Services and recipients. A basic system of resolving questions and disputes acceptable to all has been developed. The State Division of Family Services is now solidly committed to the system of fair hearings, which they believe has helped them both in administering equitably the program, and resolving disputes. H.R. 1 sets us back six years by remanding a number of basic rights, such as, in effect, that of a fair hearing. According to H.R. 1, the Department of Health, Education and Welfare will be the sole judge of fact. Furthermore, the Bill provides that a state may impose a residency requirement which the Supreme Court has already declared illegal. We urge that H.R. 1, or similar Welfare Reform Bills, retain the basic rights for recipients of assistance as they presently exist.

RECOMMENDATIONS

The following brief summarizes our concerns with the legislation being considered, H.R. 1, and lists our recommendations for changes which would make the Bill consistent with the principle of welfare reform. Most of our recommendations relate to the Family Programs Section of the Ribicoff Amendment which is co-sponsored by Senator Frank E. Moss of Utah. We understand that Senator Ribicoff has now indicated that he wishes any welfare reform program to be instituted on a pilot basis only.

We feel that no legislation at all would be preferable to the Family Programs section of H.R. 1 as it is now proposed. However, we strongly support a pilot program or a national welfare reform program which corrects the deficiencies pointed out in his testimony and incorporates either the Ribicoff Amendment or the basic recommendations outlined herein:

H.R. 1—"SOCIAL SECURITY AMENDMENTS OF 1971"

RECOMMENDATIONS

Title I. Provisions relating to Old Age, Survivors, and Disability Insurance

We approve passage of the provisions in this section relating to adult categories of beneficiaries which provide for increased benefits.

Title II. Provisions relating to Medicare, Medicaid, and Maternal and Child Health

In view of the many inadequacies we recommend either elimination of this section of the legislation or a drastic revision. The health issues involved are perhaps too complex to be adequately considered as a section of a complicated welfare reform bill, and should be handled in separate legislation directed toward providing decent health services for all Americans. For a detailed analysis of the effect of the Medicare and Medicaid provisions contained in this section we call your attention to the entitled "H.R. 1: Medicare and Medicaid Provisions" prepared by the National Health and Environmental Law Program and the University of Pennsylvania Health Law Project. We concur with their findings. Briefly, we find that the H.R. 1 provisions: 1) would substantially increase, through deductions and cost-saving features, the cost of medical services to the needy on the rationale that this would encourage cost-consciousness and discourage over-utilization, despite massive evidence that the poor do not over-utilize health services and that doctors prescribe 90% of medical services; 2) would limit Medicaid eligibility more severely than current law in Utah; 3) does not provide for a work incentive but, in fact, only a work disincentive by lowering Medicaid eligibility levels; and 4) could lead to a reduction in services. We believe that medical services should be free for all persons under the poverty guidelines. A sliding scale needs to be enacted but only for those above the guideline.

Title III. Assistance for the Aged, Blind, and Disabled

H.R. 1 would replace existing state programs of assistance for the aged, blind, and disabled with a Federal program and would assure these categories of persons a monthly income above the present state levels. Unlike the family provisions, this section would present a slight step forward in providing decent levels of assistance. At the present time a family of one in Utah on old age or disability benefits receives, including the Food Stamp bonus, \$118 per month which under the 75% of need level would increase to \$125 per month. Under H.R. 1 this level would be increased to \$130 for fiscal year 1973, \$140 for fiscal year 1974, and \$150 for fiscal year 1975. For a family of two the level of assistance at the 75% of need level would be \$152 plus a Food Stamp bonus of \$29 or \$176 total. Under H.R. 1 this level would be increased to \$195 for fiscal 1973 and \$200 for fiscal 1974. We approve this section.

Title IV. Family Programs

The purposes of this Title, as stated in Section 2101, eloquently express our desire that every citizen be assisted in securing, retaining, and advancing in employment and that everyone be assisted in improving family life and enhancing personal dignity.

Part A—Opportunities for Families

Section 2112

We believe that this section should include language clarifying standard of quality for child care facilities and programs, and assuring mothers of children some rights in selecting or approving the care provided her child. We believe that mothers with children under six should not be forced to accept training or employment. We believe that subsection (b) (4) of this section cannot be effectively implemented within the dollar limit set (800 million) and recommend that this amount be increased to provide \$2,400,000,000 for a public service employment program to provide 400,000 jobs nationally. Such a program would provide Utah with 2,000 much needed public service jobs.

Section 2115

We recommend deletion of paragraph (2)(c) of subsection (a), denying the incentive payment to beneficiaries in manpower training which has the purpose of obtaining for him a college degree.

Part B—Family Assistance Plan

(As it refers to *Part C—Determination of Benefits*).

Section 2152, subsection (b) "Amount of Benefits"

We recommend that the benefit amounts specified be increased to provide an income floor at least equal to that provided the adult disabled and close to the level of assistance presently provided in Utah, or \$1,400 for a family of one, \$2,400 for a family of two, \$3,400 for a family of four, and \$500 per additional

member. This income floor should be raised to the official poverty level within four years. A provision that present assistance payments will not be reduced in those states with higher payments for a period of at least four years should be added.

Part D—"Payments of Benefits"

Section 2171, subsection (a) (4)

We recommend the limit of the financial emergency cash advance be increased to \$300 to protect beneficiaries against delays in processing or in transmitting assistance payments.

Subsection (c) (3)—Hearings and review

We recommend continuing the recipient rights established over the years and clarification of the rights of the individual to court review of the results of all hearing procedures and elimination of the clause stating that the secretary shall be the final decider of fact.

Title V. Miscellaneous

Section 502

We recommend deletion of the prohibitions (Section 502) against participation of beneficiaries of the Family and Adult Assistance Programs in the Food Stamp Program unless assistance benefit levels are raised to 100% of needs or to establish Federal poverty guideline levels.

Section 503

We recommend provisions for incentives for state supplementation.

Section 523

We recommend retention of Section 523 establishing exclusions by state agencies of earned income up to \$60 per month per individual, plus one-third of the remainder of such income, up to a limit of \$3,000 per year.

Section 525

We recommend deletion of those parts of Section 525 which amend the wording of the original Social Security Act Section 402, substituting the word "spouse" for the word "parent," to make such spouses liable for child support without regard for applicable state laws or Supreme Court decisions.

DIVISION OF FAMILY SERVICES,
Salt Lake City, Utah, September 21, 1971.

HON. FRANK E. MOSS,
U.S. Senator,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR MOSS: We wish to convey to you our concerns about the proposed national welfare legislation now before you in Congress in the form of H.R. 1.

The newspapers have indicated that President Nixon is desirous of having this legislation completed as soon as possible, even though proposed implementation will be delayed until July 1, 1973.

In reviewing the proposed legislation and after receiving comments from our counterparts on local Boards of Public Welfare, we believe there are certain provisions that need to be carefully considered by you and by Congress.

We are greatly disturbed by the fragmentation of programs in the proposed legislation that will result in the present programs administered by the Division of Family Services being taken over by agencies of the U.S. Department of Labor, U.S. Department of Health, Education & Welfare, Social Security Administration, and the residue of these programs, not allocated to other agencies, remaining with the state organization. It seems that one agency should be assigned the mandate to provide supporting services—day care, transportation—for all recipients rather than as H.R. 1 now provides.

The elimination of food stamp participation for those families receiving money grants, even though they may be given an equivalent of money, would undoubtedly deprive many children of an adequate diet. The money received in cash would go for many items other than food and would not increase food budgets to the extent food stamps do.

The provision of allowing the payment of a maximum \$100 on an emergency basis by local administrators is totally inconsistent to the basic needs of certain size families. No provision to issue more than one grant will undoubtedly create severe hardships for many applicants.

We believe that the removal of these programs from the state level to federal level would possibly result in the lack of response to the needs of individuals and families which could be more realistically handled on a local level. It further removes the local concern to resolve the social problems which create the dependency.

The option, which is left to the states to supplement fully-funded basic maintenance payments, could result in many states, including Utah, refusing to supplement the federal program and thus reducing the level of payments now being provided to meet minimum standards of living in the various states.

In contrast to our concerns about the specific provisions in H.R.-1, we would like to express our recommendations for specific improvements in the bill or new concepts that we believe would enhance or improve the overall operation of welfare in the United States. These statements are as follows:

1. Improvement could be made in H.R.-1 by retaining the present organizational structure, and

(a) Establishing uniform, standardized levels of payments across the nation;

(b) Establishing uniform eligibility requirements across the nation;

(c) Establishing uniform definition of income and exemption of income (income disregard).

2. Permitting states to relate supplemental payments to residency requirements and providing federal matching in supplemental payments as an inducement for the states to meet the needs of people on a level of payment that the state has the resources to provide.

3. Abolishing all categorical programs of assistance and replacing them with one program for all persons who are in need of assistance.

4. Providing and assuring that every able-bodied recipient has the opportunity to work or to receive training that will prepare him for employment.

Such actions would avoid the creation of new federal bureaus at a time when national trend is to be conservative.

Sincerely,

PAUL S. ROSE, *Chairman.*

Senator TALMADGE. The next witness is Mr. E. T. Dibble, Management Systems consultant, Atlanta, Ga.

Mr. Dibble. I am delighted to welcome you as a constituent and friend of our committee. You may proceed, sir.

STATEMENT OF E. T. DIBBLE, MANAGEMENT SYSTEMS CONSULTANT, ATLANTA, GA.

Mr. DIBBLE. Thank you, Mr. Chairman.

I am not here representing any group except the taxpayers for which I can only speak for myself. My educational program netted out for you, I have a bachelor's and master's degree in petroleum geology. I am a systems analyst by profession and I am going back next quarter to work on my doctor's degree in management information systems.

For the past 3½ years it has been my opportunity to work for HEW in an offhanded way, and I work for a private concern which had a contract through the State of Florida to work on a management information system for the welfare load. I guess would be the best way to put it.

We developed the systems side to make the program work. This was a program oriented, and I differentiate program with a capital "P" to assure everybody here it was not a computer program. It was

a people oriented welfare program. Our job and my job as project systems manager was to provide the means so that the welfare program people could have the data to operate on. My experience in this project, known as the case and administrative service system or CASS for short, took me into three States which were participating in the program: Florida, Maine and Minnesota. I commuted from Atlanta to these States on a weekly basis leaving on a Monday morning and getting back on Friday night.

At the request of the then Commissioner of CSA in HEW, Mr. Steve Simonds, I took a leave of absence from the firm I was with and became a consultant here in HEW to CSA, to develop the management information system. My primary concern is, as I have explained to other Congressmen, I feel you gentlemen are not getting what I feel is valid information with which to make decisions affecting everybody who has testified this morning as well as the rest of the taxpayers.

I have personal feelings about H.R. 1 and welfare in general which I will not get into because that destroys my objectivity. My goal is, as a systems analyst, to provide management with the information to make valid decisions with. The primary concern that I have this morning is, and I am not going to read that statement because it is pretty self-explanatory, but I will get into other details, that nobody really knows what is going on in welfare. When we talk about welfare reform we don't really know what we are basing our decisions on because the information we get by virtue of the system we have today probably is invalid through nobody's cognizant efforts. I guess, nobody can say, I don't believe anybody is honestly making an effort to defraud, you know, Congress or their State legislatures, and so on. There may be a few welfare recipients who are, but nobody really knows without doing a physical manual audit and I have been involved in one of those in the firm and obviously there are a few people who ruin it for the many.

The problem you really run into a place, in a State, where a welfare recipient lives on the boundary, say, between two cities. Without naming names, they can go to one city for services they get a case number there. They go to another city for payment and they get another number there. They report it to the research statistics people at the State level, the people of that agency gets a count of one family from one family and one from another and you get a count of two. Department of Labor representatives report them under their system, OEO reports them under their system, this happens, and by the time it gets up to Congress the group you are really concerned with gets four cases instead of one.

Senator TALMADGE. Will you yield?

Mr. DIBBLE. Yes.

Senator TALMADGE. Let's see if I understand what you are talking about. We will assume a citizen of Atlanta, Ga, applies for welfare assistance there, and then goes over to North Carolina and applies for medicaid, and goes down to Alabama and applies for some form of public assistance down there, and goes down to Mississippi and applies for another form of public assistance and is receiving benefits from four different States simultaneously under four different code names. Is that possible?

Mr. DIBBLE. I think it is possible. I think it is perhaps frequently unconsciously because people living in Columbus, Ga., let's say, they get payment there and get payment from Alabama for social services because there is no Federal definition for family. The workers in the field have the burden put on them to make a judgment as to what they are talking about.

I have been proposing and made the proposal to numerous people, that there should be a—I always hate to say it because I spent 6 hours in Senator Ervin's office reading testimony in leisure there, but I don't see any way to get around, a unique identification method for the terms that we are interested in, family, head of family, family member, household. My private concern is that the definition of household as is written up in H.R. 1 will not work when it gets out into the field when it becomes operational. I have discussed this with friends of mine in the FAP systems planning group. I have talked about the proposal for this numbering system we are talking about here with people from Social Security, Department of Labor and FAP and basically we are in agreement. But there are always reasons why, somebody says "But my business is different."

When I was working as an IBM salesman I never ran into a customer or prospect who didn't say his business wasn't different, I installed business equipment from Litton Industries to a wholesale lumberyard. This concept was tested. I don't say implement the concept exactly as we tested it in the field, but the concept seems to be valid, perhaps more work needs to be done. I am not going to make that judgment. All I am saying is this could be a solution, the social security account number could be used to derive a family unit number, and again I think legislation has to be provided and it is incumbent upon you gentlemen to provide this legislation to insure the privacy of the individual. Obviously, information can be cross-referenced from one file to another, any systems analyst can tell you how to do it. They can also tell you how to protect the individual privacy if given the opportunity.

I think in any business, and welfare is a business today, you have to have uniform definitions and a standard chart of account numbers apply across the business; in this case across the United States. You can't have, for instance, in the State of California, 49 counties each with their own numbering system, each with their own set of rules, everybody should be using the same Bible, at least in a case like this.

Senator TALMADGE. Will you answer this question, please. It has been suggested by some members of our committee and perhaps other witnesses that we use the social security number as a means of identification and they have pointed out, for instance, that if a father abandons his family and his children in Atlanta, Ga., and gets a good job up in Detroit, making \$10,000 a year. But he would prefer that the taxpayers support his family rather than supporting them himself. With some means of universal identification, we could immediately flash the signal where he could be located and be held responsible for his family.

Mr. DIBBLE. If Congress were to mandate that is the way they wanted a system to operate, yes, you could. Now that is assuming a lot.

Senator TALMADGE. Will you please state in writing what you suggest this committee incorporate into the law and give it to our staff at some time?

Mr. DIBBLE. Yes, sir.

Senator TALMADGE. I think you have made a helpful suggestion here. Our committee has long since arrived at similar conclusions but I don't think we have yet reached a consensus as to the mechanics of what we ought to do. You, as a systems analyst who has worked in that field and made suggestions to HEW, could perhaps provide us with some very helpful suggestions. I appreciate very much your appearing here.

Any questions?

Thank you very much and it is an honor to have you before our committee.

Mr. DIBBLE. Thank you.

(The prepared statement with attachments of Mr. Dibble follows:)

PREPARED STATEMENT OF E. T. DIBBLE, MANAGEMENT SYSTEM, CONSULTANT,
ATLANTA, GA.

SUBJECT: NATIONAL WELFARE NUMBERING SYSTEM

The following comments summarize my conversation with Senator Talmadge, related to a National Welfare Numbering system to be used as the basis for uniform accounting by local, state and federal agencies.

1. From the viewpoint of the recipient, the taxpayer and Congress, the issue of results from money spent, or to be spent, on welfare efforts is of great concern.

2. Logically, before results can be tabulated and judged, there must be some valid accounting method provided and controlled by management; in this case the Federal government.

3. Most accounting relies on a uniform "Chart of Accounts" developed for the application. For each account number there is a valid, workable definition which limits the amount of interpretation allowed the person working with the ledger. For audit purposes this is a prerequisite.

4. In our welfare system, this uniformity does not exist, which precludes valid accounting or judging results on a detailed basis.

5. There is an urgent need for a system which allows workers in different agencies and jurisdictions to aid the recipient, the Program administrator and staff to properly manage their resources, and for Congress and the taxpayer to receive unduplicated information based on uniform definitions and accounting procedures.

6. The recent Case and Administrative Service System project, an H.E.W. demonstration project, tested the feasibility of various concepts. One of these was treating the family as a unit, thus enabling an agency to render better service. In order to do this, Program staff voiced the need to identify an individual and be able to then relate the individual to a family unit, and vice versa. Another concept tested was a numbering system which enabled both of these goals to be achieved. (see exhibit 1).

7. The validity and usefulness of these concepts was demonstrated during the nine months field test, after three years of preparation, in three states. The concepts are being used today in on-going systems in different states, with local modification in lieu of Federal guidelines. The numbering system was successful in satisfying both Program and statistical requirements.

8. If desirable, the use of Social Security Account Numbers could be the base for derivation of the Family Unit control number used by this concept. No revision to the system would be necessary to meet this requirement. Proper legislation should be provided to assure individual privacy. (see exhibit 2).

9. This concept has been discussed with representatives from various agencies with the general concurrence that a common numbering system and uniform set of definitions is not only desirable, but necessary.

This system will work. It will require specific action steps to analyze, design and implement it on a nationwide basis. It won't be easy or accomplished in a short time, but the results could shape the course of welfare in future years.

February 2, 1972

EXHIBIT 1

ARTHUR YOUNG & Co.,
6935 WISCONSIN AVENUE,
Washington, D.C., August 20, 1970.

MR. STEPHEN P. SIMONDS,
Commissioner of C.S.A., Department of Health, Education and Welfare, Wash-
ington, D.C.

Attached is a copy of the numbering system used for the Case Administrative Service System. As you know, CASS is a demonstration project to test the feasibility of various concepts. One of the concepts was treating the family as a group, thus enabling an agency to render better service. In order to do this, the Program staff voiced the need to identify an individual and be able to then relate the individual to a family unit. Conversely, they specified, it is necessary to be able to identify the family and be able to identify the members and their relative role in the family. The concept used with the CASS numbering system enables both these goals to be achieved.

The validity and usefulness of the numbering concept has been demonstrated during the nine months of the test period, and is being used with minor modification to local conditions in one of the test states (Florida). It would be possible to expand the concept and adapt it for use by the Department of H.E.W. throughout the United States. To do this would entail some specific tasks which we are proposing as a project under the direction of C.S.A. This would accomplish at least two goals. One, it would enable the numbering system to be tied to the definition of Family as developed by C.S.A., and two, it could then be coordinated through C.S.A. with the other needs of the department. One of the prime needs that immediately comes to mind is with the F.A.P. system that is currently being developed. As you know they are working on a means of identifying individuals, although for service purposes there seems to be a need to identify the family.

A brief review of some tasks involved, in not only agreeing upon a common numbering system for use by all Departments of H.E.W., but for actually planning implementation, is in order. A few of the tasks are:

Determine the Agencies needs for family and individual identification, both at the State and Federal level.

Evaluate the present systems to determine any commonality between systems in use by all agencies.

Evaluate the environment of staff, administrators, and legal advisors in the locality affected.

Determine the actual implementation problems at Federal and State level. This could be affected by local conditions such as type of administration (local or state), training requirements, equipment presently used, availability of manpower and time.

Determine the mechanics of actually converting existing systems to a Federally assigned number.

Determine the role of the Social Security Administration and the Individual Identification Number as promulgated by the National Bureau of Standards.

Because of the widespread and urgent interest in this problem we would like the opportunity of an early meeting to discuss this proposal with you.

Very truly yours,

ARTHUR YOUNG & Co.

EXHIBIT 1

C.A.S.S. NUMBERING SYSTEM¹

CONSTRUCTION OF CASE NUMBER

XXXXXX 6 Digits comprise the Family Unit Number.
YY 2 Digits comprise the Family Member Number.
XXXXXX-YY 8 Digits comprise the Case Number.

Example: 123456-01—This 8 digit number is the Case Number for the "Legal Male Head" of Family Unit 123456. 01 is always the Legal Male Head as defined below:

¹ Not proposed as the National Welfare Numbering Concept.

00—Conceptually the "family" is considered an individual with certain characteristics.

01—Always the Legal Male Head of the family.

02—Always the Legal Female Head of the family.

03—Reserved for future use.

11—Oldest Child in family.

12—Second oldest child in family.

Continue in sequence for other children.

To illustrate the use of the CASS Numbering System consider a female child in one family who marries, divorces and then remarries. The record of her Case history could be shown as follows :

Year	Present	Previous	
1969	123456-02	432561-02	During the year 1969 she divorced, remarried, and received present case No. 123456-02.
1968	432561-02	354260-11	During the year 1968 she married and became the legal female head of family 432561.
1967	354260-11	In 1967 she was the oldest child in case 354260, with no previous case number.

NOTE.—Exact dates are kept to show when the changes took place and could be retrieved if necessary.

EXHIBIT 2²

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, SOCIAL AND REHABILITATION SERVICE, COMMUNITY SERVICES ADMINISTRATION, March 25, 1971.

Subject SSA # for Welfare.

To: Stephen P. Simonds, Commissioner.

STEVE: Netting it out, here are the pros and cons of using SSA # for Welfare.

PROS

1. It is an easily derived number
 2. It can be checked for validity through existing SSA procedures
 3. A number can be acquired within about 10 days for those not having one
 4. Reporting to I.R.S. is by SSA #
 5. Reporting to Unemployment is by SSA #
 6. Reporting to DOL (WIN) is by SSA #
- Accounting procedures for welfare could be tied into these reporting systems
7. Information from different agencies, related to the same family, could be more easily kept track of
 8. Reports sent to NCSS for use of HEW would reflect unduplicated counts, if properly implemented.
 9. For proper evaluation and accountability throughout HEW it seems necessary to use a common account number for one family.
 10. If necessary, information could be exchanged between agencies using the SSA # for the link

CONS

1. A client could probably go to court and obtain an injunction against the use of SSA # for keeping track of their records. The answer to this to immediately come out with a position paper on control and access to information (as Secretary Richardson suggested).
 2. The most obvious concern is the one of invasion of privacy The answer to this to immediately come out with a position paper on control and access to information (as Secretary Richardson suggested).
 3. Clients are not apt to have their SSA # readily available to them. This is the same problem States encounter with Medical numbers and have resolved this problem to the benefit of the Clients.
- Fankly, thinking this problem through as best I can, it is difficult for me to arrive at any valid opposition to the use of SSA # for the derivation of Family Unit number.

EDWIN T. DIBBLE,
Consultant/CSA.

² Excerpts from Lowler paper.

Senator TALMADGE. The final witness is Mr. James H. Heller, Chairman of the American Civil Liberties Union.

STATEMENT OF JAMES H. HELLER, CHAIRMAN, AMERICAN CIVIL LIBERTIES UNION

Mr. HELLER. Mr. Chairman and members of the committee, I thank you very much for the opportunity to testify today. I will try to see that you don't end with a total whimper here instead of a bang in my testimony. I will not read my statement in full. I simply—

Senator TALMADGE. It will be inserted in full in the record and if you would summarize it we would appreciate it.

Mr. HELLER. I appreciate that.

As I indicated in the beginning of the prepared statement we have four basic foci of concern with this bill. The first one is the area of privacy. You just were talking about that with the last witness. I kind of fear that the complexity of computer terminals and systems for relating data in this world is too great for anything that this committee can do in the language of the law except sternly, I think, and we have urged this strictly to enjoin upon the administrators of this law or any other welfare law or any other general Federal benefit law that the information received should be the minimum necessary and should be only used for the purposes of that law. Whether a social security number is used, a tax reporting number or a new identification system, undoubtedly there will be ingenuity and machinery to relate it to other information in the Federal, local, and State data banks, but the problem, and the problem we have encountered with FBI files as well, is somebody must enjoin the administrators of the Federal act to keep the information to themselves and use it only when it should be used for that program. They didn't get it for any other purpose and it should not be used for any other purpose.

Privacy is an essential matter here. Many of the other civil liberties problems in this bill, H.R. 1, as we see them, can be resolved as a matter of fact. The Ribicoff amendments, the Harris substitute, the McGovern substitute, on civil liberties grounds are all infinitely preferable on the points that we make in this statement. Moreover, if they are not resolved, we can anticipate that in many respects the courts will resolve them in a way that they must be resolved as a matter of fairness and dignity to the individuals under this program.

Privacy, however, is a matter which this committee must take up because this is an area in which Congress must dictate to the administrative branch of the Government what is required for human decency and for that area of all our lives that we want to keep to ourselves or at least as much to ourselves as we can.

I think really this is the most important single thing that must be put in this law by this committee before it goes out to the Senate floor. The Senate has always had a great sensitivity to civil liberties.

One of the other areas we have talked about is procedural fairness and we particularly talked about a right to a hearing before welfare cutoff exactly as the Supreme Court indicated in *Goldberg v. Kelly*. I recall when the Senate debated the Civil Rights Act of 1964, title VI, the funds cutoff for federally assisted programs, was the focus

of concern. There were lengthy concerns, days, weeks, months about prior hearings and the rationale, north, south, east, and west requiring hearings before cutting off funds that those programs all have beneficiaries behind the agencies who immediately receive the money. It can't be that in welfare this committee or the Congress means not to insure explicitly that there will be a prior hearing, a prior hearing held promptly, with reasonable opportunities for the recipient to prepare, but certainly a prior hearing before there is a fund cutoff. There won't be any departure from the traditions that the Senate has upheld on that point, I hope.

There are arbitrary standards in this bill. They, too, suffer by comparison with the Harris and McGovern and even the Ribicoff bill, standards which don't allow people to question the suitability of work even though it may really be injurious to their health. Standards which don't allow parents to question whether their children are getting adequate day care even though that is also essential decency and in effect, peonage of children if it is terrible care, and even though as a matter of fact this is a bill designed to increase parental responsibilities and produce new generations of people who will be better off than their parents.

We must again, I think, give consideration to dignity and decency throughout the bill.

There are some lesser provisions we object to, such as reintroduction of a minor version of the man-in-the-house rule, the responsibility of a spouse of a parent to contribute his income to the family in which he is only a step parent, whereas he may have another family for which he is really legally responsible.

Running all through this, aside from dignity, I think is the question of equal protection under the law. All of us do apply for Federal benefits. We all expect to be treated fairly and to have the minimum rules and requirements imposed upon us for reporting or divulging our private lives. We all expect to have fair warning of the changes in the rules. We all expect to have standards that don't assume something that is not true, such as that black is white and white is black. There are provisions in this bill we have outlined, and others have too, which really don't meet those standards and they raise, therefore, a question of equal protection of the laws.

The Washington Post, if I may say so, had a very interesting editorial this morning in which they said a few policemen in the District of Columbia police force—and I am from the District of Columbia, I am the Civil Liberties chairman for this area—a few policemen have been accused of misconduct, there have been rumors of a few more. Everybody has said it is a few. We have a 5,000 man police force and nobody thinks that the police force is calumnified by this or is all suffering from the same shabby standard that a few might. That must be true as well of welfare recipients, the least privileged people in our society. This bill, I think, must recognize that basic truth.

Thank you very much for hearing me.

(The prepared statement of Mr. Heller follows. Hearing continues on p. 2382.)

PREPARED STATEMENT OF JAMES H. HELLER ON BEHALF OF THE AMERICAN CIVIL LIBERTIES UNION

Mr. Chairman, members of the Committee, my name is James H. Heller. I appear here today on behalf of the American Civil Liberties Union to express

its views on the civil liberties aspects of H.R. 1 and the other proposals being considered by your Committee for major revision of our welfare programs.

Our concern with such legislation has always had certain focal points. These are: protection of the rights of privacy of those assisted under such programs; the use of standards which are free from arbitrariness; procedural fairness and use of standards which do not penalize or inhibit the right of our citizens to travel freely and live where they wish.

It goes without saying that personal dignity should be an essential underlying consideration in the drafting of legislation such as this. As the Board of Directors of the ACLU stated in 1969, "To be poor is tragedy enough. To be forced to forego elementary rights of privacy and decency in order to obtain financial assistance is improper and violates the fundamental precepts of a democratic society."

There is a related consideration which has practical as well as legal and philosophical importance, as is commonly true of civil liberties matters. Our papers and airways have been filled recently with indignant comments about "Welfare chiselers" and people "feeding at the trough" of government assistance. But if we truly expect assistance recipients to benefit from these programs and to achieve insofar as possible, economic independence, the programs themselves must accord them a full measure of dignity and fairness. Regrettably, there are features of the H.R. 1 now before this Committee which do not meet this standard and are, to that extent, likely to be self-defeating causes of just resentment on the part of those to whom they would apply.

In 1969, the Supreme Court ruled in *Goldberg v. Kelly*, 397 U.S. 54 (1969), that it was unconstitutional to deny an individual welfare benefits he or she has been receiving before giving that individual a hearing, whereas in other situations a hearing *after* the adverse determination might be permissible. In reaching this decision, the Court highlighted the essence of the problem when it pointed out that for welfare recipients those benefits are "the very means by which to live." As the Court said, a welfare recipient "lacks independent resources, his situation becomes immediately desperate. His need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy."

A person in such straits is not likely to measure up to high preachments about self-reliance and "turning square corners." Therefore, as a practical matter as well as a matter of basic respect for civil liberties, it behooves the Congress to "turn square corners" in this bill by framing legislation which embodies fairness at every turn.

It is in this context that we have the following comments to make on the principal welfare reform proposals before the Committee. We have concentrated on H.R. 1 as the basic proposal before you. However, we urge the Committee to examine, for solutions to the problems which concern us, alternative measures before you, particularly those principally sponsored by Senators Harris (S. 2747), and McGovern (S. 2372), and, to a substantial degree the Amendment offered by Senator Ribicoff (Amendment 559 to H.R. 1).

PRIVACY

We are all concerned with the growing web of information requirements and central data banks which threaten to denude Americans of what many think to be our most precious right of all, fundamental privacy vis-a-vis other citizens and the government. No class of persons is more threatened by this growing phenomenon than those enrolled in public assistance programs. Certain undesirable welfare practices are more easily corrected than others. Welfare recipients may protest the midnight investigation, the arbitrariness of the "man-in-the-house" rule, or the arbitrary cut-off and hearing procedures. They are less likely to fell themselves enabled to protest the information requirements on application forms or interview forms which they must fill out in the first instance even to gain eligibility. Yet the privacy of these individuals is often most egregiously infringed at this point.

Proponents of welfare reform have long urged that welfare applicants simply be required to fill out forms without having to agree to home visits and other intrusive forms of investigation not inflicted on other applicants for government benefits. Yet, the House Ways and Means Committee, in its report accompanying H.R. 1 (House Report No. 92-231, page 161) underscored its determination that, "there will be no simple declaration process" for establishing eligibility. There is no reason why that should be so. The risk of fraud, which can be the

only justification for which a rule, is just not so great a risk, since the backing for a declaration procedure is the threat of prosecution for giving false information. There cannot be a more meaningful threat. It might be pointed out that in the District of Columbia we now use a very simple declaration process for registration to vote even though voting is a precious right and over the years voting frauds have rivaled welfare frauds in the political life of this country.

But if more than a declaration procedure is to be employed, the Congress should at the very least require expressly that it be as simple and as spare as possible, with the least possible intrusions on individual privacy.

Beyond that, there should be statutory protection of the confidentiality of the information received. This includes not merely divulgence to persons outside the government, but divulgence to other public officials and agencies of the government. There should be a flat prohibition on the use of such information for any purpose not related to the administration of the welfare program itself or to the basic statistical needs of the government. Such a prohibition should include, above all, law enforcement programs not related to the welfare program.

The opportunities for wrongful divulgence of information through mismatched computer terminals and other abuses are so complex and manifold that it may well be impossible to legislate against them in specific terms. That is why we suggest a flat prohibition with the exceptions noted and urge the Congress to maintain a continuing watch over this problem, as Senator Ervin's Subcommittee on Constitutional Rights has attempted to do in the area of government employment and in other areas where the potential for misuse of data to strip citizens of their privacy has become most pronounced.

The problem of privacy will be escalated when the welfare program is federalized because the body of personal information will be centralized. We are dealing here with a genie that, once out of the bottle, will be almost impossible to stuff back in. There is not a person in this country who does not have to register for some governmental benefit or requirement. All of us have the right to expect that the information which we provide in registering will be confined to the uses for which it was required in the first place. Welfare recipients ought to have that protection as well. Our experience in these problems leads us reluctantly to the conclusion that if Congress itself does not spell out standards in this enabling statute, the necessary sensitivity to privacy simply will not exist.

Both S. 2747 and S. 2372 address themselves to the question of privacy in a constructive and laudable manner. Both bills provide that "all records kept by the Secretary shall remain strictly confidential and may be used only by the Secretary to effectuate and enforce the provisions of this Act," with the exception that the enrollee is guaranteed the right to examine his own file. See Section 2006(c) (10) of S. 2747 and Section 11(j) of S. 2372. Moreover, those proposals command the Secretary to use simple and understandable enrollment forms. S. 2747 further stipulates that, "Information required must be reasonable and necessary and must not violate the right of privacy of the claimant or of any member of his [family] unit." Section 2006(e) (1). Provisions such as these should be included in any measure reported out by the Committee.

Certain provisions of H.R. 1 do not meet the test of substantive fairness required by our constitutional guarantee of due process of law. That is, they incorporate standards or presumptions which are arbitrary in many foreseeable applications. The problem is aggravated because some of these provisions either do not provide, or unduly restrict, an administrative remedy for the victims of such arbitrariness.

It may well be that the courts would themselves invalidate such standards and would in any case provide a remedy if Congress did not. But this means of resolving statutory deficiencies is itself unfair for obvious reasons. First of all, by its very nature, a law applying to million of persons unable to afford the necessities of life, much less legal representation, ought to be drafted with special attention to clarity and fairness of standards. Moreover, to the extent that standards have the potential to be unfair or arbitrary in specific situations, the law itself ought to provide the remedy, so resort to the courts is not necessary. If courts must intervene, they are likely to interfere with orderly administration and the remedy they provide is likely to come too late for many who need it. It is far better to minimize the need for their intervention.

The two most serious examples of arbitrariness occur in Sections 2111(c) and 2112 of H.R. 1. The first provision sharply limits the ability of persons who are required to register for work or work training to question the suitability of

employment offered to them. The second provision completely fails to provide any opportunity for a working parent to question the adequacy of care for his or her children.

Section 2111(c) gives added offense because, as the Committee knows, it provides a minimum wage standard for private employment which is only four-fifths of the current Federal minimum wage. Thus a registrant for employment may be required to accept work at substantially lower pay than any other person doing similar work whose wages and hours are regulated by Federal law. The wages may even be lower than those paid the person next to him in line at the registration office who was sent to work for a public agency at the legal minimum wage.

Section 2111(c) takes no account of the possibility that the work assigned to a registrant may be totally unsuitable for him or even dangerous to his well-being. We believe that a court would hold this requirement tantamount to peonage in some situations. But we really seriously question whether Congress wishes to enact a standard which entrusts such matters to unfettered administrative discretion. It should be noted too that Section 2114 of H.R. 1 does not provide for any consultation with the enrollee in developing his "employability plan."

Of the four major proposals to which we have referred, H.R. 1 is by far the most limited in its provision of opportunity to challenge the suitability of work or training offered to an enrollee. Indeed, the McGovern bill does not even contain an involuntary work requirement. Both the Harris and Ribicoff proposals contain important and detailed safeguards in the form of requirements imposed upon the Secretary of Labor in selecting suitable work and "good cause" reasons for an enrollee to refuse to accept work as unsuitable. Sections 2111 and 2114 of the Ribicoff proposal and Section 2008 of the Harris bill contain the type of protection that ought to be made a part of any work requirement approved by the Committee. Those proposals likewise command that at least current Federal minimum wage shall be paid for all such work.

The other key example of arbitrariness concerns child care. We do not understand how Congress could even contemplate forcing a parent to put his or her children into the care of another person without providing an opportunity to question the suitability and quality of that care. On the most minimal level that would be inexplicable in terms of the desire to encourage better parental responsibility. There is growing awareness that all across the country there are foster homes and day care institutions which indeed are totally unfit to assume responsibility for children. Moreover, there are children with special problems that can only be dealt with by people having special training. We simply assume that the Secretary of HEW and his subordinates will be able to deal with these problems so well that there need be no opportunity to question their judgment in individual cases. No concerned parent would agree to commit his or her children to the care of others on such a basis.

The provisions of the Harris and Ribicoff proposals cited above include inadequacy of day care arrangements as one of the "good cause" bases for refusal to accept offered work. As pointed out, the McGovern measure avoids these difficult civil liberties questions altogether by providing that there shall be no involuntary work requirement.

H.R. 1 appears to be filled with provisions which have the effect of penalizing those who need assistance the most. Section 2155(d) of H.R. 1, for example, represents a modest, but nonetheless disheartening, reintroduction of the man-in-the-house rule. It provides that the income of a stepfather or stepmother is deemed to be available to the other members of the family. Obviously, however, the step-parent may have primary legal responsibility to others and therefore may be put in a vise between two conflicting legal requirements. The real victims will be the current spouse and his or her children, who are presumed to have available to them income which is not in fact available because it is committed elsewhere. The three alternative measures offered by Senators Harris, Ribicoff and McGovern avoid this problem completely by stipulating that the income of a family member shall not be deemed to be available to a family unless that person has an obligation of support under the law of the state in which the family resides.

Another instance in which H.R. 1 appears to penalize dependents for the delinquencies of parents is Section 2171(e) (2), under which benefits may be cut off to the entire family because of failure of a parent to submit a timely report on benefits received during the previous calendar quarter. Also, Section 2171(a) (2) (C) permits the denial of benefits to any family because of failure to register for employment or accept employment or training or other rehabilitation services; but at least that provision authorizes the Secretary to continue such bene-

fits in his discretion. By contrast, Section 2171(e)(2) appears to give the Secretary no such discretion. Similarly, Section 2152(g)(1) cuts off benefits to a whole family because one member refuses to accept offered (but possibly unsuitable) employment. In general, we question in any case those provisions of the law which penalize dependents for the sins of omission of their parents or guardians.

PROCEDURAL FAIRNESS

It has been pointed out above that some of the basic requirements which H.R. 1 would impose on welfare recipients are not subject to administrative challenge or hearing at all. In those cases, there is a total lack of procedural fairness.

There are two features of Section 2171(c) which severely limit the fairness of even those hearings which are provided for in the bill. In light of *Goldberg v. Kelly*, it should certainly be made explicit that a hearing must be held prior to the cut-off of welfare assistance. Perhaps the House Ways and Means Committee may have assumed that this and other basic procedural requirements for such hearings would be incorporated as part of general standards of administrative due process or pursuant to the requirements of the Administrative Procedure Act. But whether welfare is administered by Federal, State or local officials, it will inevitably be in the hands of thousands of different persons before whom innumerable hearings will be held. The basic standards governing those hearings ought to be clear, full, and fair, and they should be written out in the governing statute.

Section 2171(c)(3) also provides a standard of judicial review which purports to cut off all such review of administrative fact determinations. As a part of administrative due process or of statutory standards of review, courts have regularly upheld the right of the judiciary to reject factual determinations which are arbitrary and capricious or which do not have substantial evidentiary support in the administrative record. In the main area where such judicial review has been curtailed by Federal statute, government procurement (see 41 U.S.C. 321), the rationale has been that the further curtailment was really based on the contract of the parties. Thus it was reasoned that the parties had contracted to limit the review of the contracting agencies in a dispute. But there is no such contract between the welfare beneficiary and the government. Certainly the beneficiary cannot be deemed to have agreed, or be required, to accept an arbitrary factual determination cutting off his or her basic subsistence.

Section 2171(a)(2)(C) provides no hearing in a case where the Secretary decides to pay benefits to a person outside of the family because of asserted failure of a member of the family to register for or accept work or training under Section 2111. By contrast with Subsection (A) of Section 2171(a)(2), which provides for a hearing if payments are made to a third party because of asserted inability of the family member to manage his funds, Subsection (C) appears to contemplate no such hearing. Moreover, because it refers back to Section 2111 which, as we have observed, narrowly limits challenges to the suitability of offered training or employment, Subsection (C) incorporates that arbitrary standard by indirection. We believe Section 2171 should be amended to remedy these deficiencies.

In these procedural areas, the Harris and McGovern proposals are notably more explicit and more protective of the liberties of those subject to the program. See Section 2006(c) of S. 2747 and Section 11 of S. 2372. In addition to providing for administrative hearings prior to cut-off of benefits, both bills specify that decisions in the first instance shall be subject to further administrative review and "shall be fully reviewable" in the Federal courts. We understand this language to rebut any claim that administrative fact determinations are binding upon the courts, no matter how arbitrary or capricious they may be.

In general, both the Harris and McGovern proposals show a greater concern for procedural safeguards, including provisions for the payment of hearing and litigation expenses where the assistance beneficiaries are unable to meet those expenses—as will commonly be the case. The Harris bill also provides a fuller measure of procedural protections, and a more limited basis, for making welfare payments to third parties in lieu of the eligibles themselves. The McGovern bill does not provide for third-party payments at all.

An important procedural protection which is expressly incorporated in the Harris and McGovern bills and has no counterpart in either H.R. 1 or the Ribicoff amendment is an express requirement of notice and public hearing prior to change in rules and regulations. Moreover, notice must be given directly to groups certified and registered as organizational representatives of assistance recipients, and periodically the Secretary must give direct written notice to all

assistance recipients of the current requirements and rules of the program. These are obviously important protections under a law which affects millions of persons who suffer from educational as well as financial disadvantages and who confront nearly insuperable problems in learning about day-to-day changes in administrative requirements. H.R. 1 contains another cut-off provision which could have drastic consequences on affected individuals. Section 2175 permits the Federal government to withhold unilaterally any payments due under other provisions of law (e.g. veterans benefits) from a person who is alleged to have deserted or abandoned his spouse or his children who continue to receive government welfare benefits.

The Ribicoff amendment contains the same offset provision. The Harris and McGovern bills do not. This provision for unilateral offset and withholding without a prior hearing could be cruelly unfair. Again, we refer the Committee to the sound premise of *Goldberg v. Kelly*, supra—that the Constitution does not permit welfare recipients to be deprived of their benefits without a prior hearing, because they have no alternative resources to support themselves while the argument goes on. Section 2175 ignores that principle.

BASIC FREEDOM OF MOVEMENT

Two features of H.R. 1 affect the basic liberty of Americans to move freely within this country. One of these, Section 2156(c), permits states to impose a residency requirement of up to one year for supplemental state benefits. This is contrary to *Shapiro v. Thompson*, 394 U.S. 618, the Supreme Court's 1969 decision, and to the recent action of the Court in summarily affirming two lower court decisions striking down residency requirements, *Wyman v. Lopez*, No. 71-620 and *Dunn v. Rivera*, No. 71-679, 40 Law Week 3346 (January 25, 1972). No similar provision in the Harris, Ribicoff or McGovern proposals appears.

Section 2176 would enact a sort of Federal criminal non-support law, based on interstate flight to avoid the duty of support. We believe this to be an unnecessary and needlessly stringent provision. We are not aware of any lack of cooperation among the states in dealing with serious cases of interstate flight to avoid the duty of child or spouse support. Moreover, we believe civil remedies have proved both fairer and more effective to deal with this type of problem. We would regret exceedingly any attempt to impose a Federal panel requirement to deal with a problem of this sort. While the Ribicoff amendment preserves this bad feature of H.R. 1, the Harris and McGovern bills contain no criminal penalties, but make the deserting parent severely liable to the Federal government for support and maintenance which the government provides to his or her dependents.

CONCLUSION

Running through all these civil liberties problems in H.R. 1 is an underlying question of equal protection of the laws. This constitutional guarantee simply does not permit the Congress to legislate different standards for the poor and needy than those applied to the vast majority of our citizens in their dealings with the government. As has been pointed out above, there is not a person in this country who does not at one time or another have to register with the government either to receive benefits or to satisfy some information or licensing requirement. On the whole, because we see ourselves in the same situations, we have insisted that these requirements be fair and impose the least burden necessary on the citizen. Moreover, where the generality of standards has created the threat or arbitrariness in specific situations, we have insisted upon the fairest of administrative procedures and remedies.

The provisions of H.R. 1 simply do not measure up to this standard. There is an implication that this law is addressed to a suspect class of people who must be dealt with more harshly. Such underlying assumptions must be laid to rest before real progress in welfare reform which takes account of human dignity can be made. We urge this Committee and the Congress to correct these civil liberties dangers so that the legislative effort in this area will be directed solely toward the betterment of the lives of so many of our citizens.

Senator TALMADGE. Thank you for appearing.

Any questions? If not we will stand in recess until 10 o'clock Monday morning.

(Whereupon, at 12:50 p.m., the committee was adjourned until Monday, February 7, 1972, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1971

MONDAY, FEBRUARY 7, 1972

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 o'clock a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Ribicoff, Byrd of Virginia, Nelson, Bennett, Curtis, Jordan of Idaho, Fannin, and Hansen.

The CHAIRMAN. The committee will come to order.

The first witness this morning will be Dr. Hollis S. Ingraham, president of the Association of State and Territorial Health Officers.

We are pleased to have you, Doctor.

Dr. INGRAHAM. Senator Long—

The CHAIRMAN. We have your statement here which we will print, and I suggest that you summarize it.

STATEMENT OF HOLLIS S. INGRAHAM, M.D., PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Dr. INGRAHAM. Senator Long and members of the committee, I appreciate very much the opportunity of being here and I shall read simple excerpts from the testimony that I have submitted.

The association, in general, strongly favors the thrust of the legislation but does wish to comment on certain aspects of the medical care provisions.

For example, H.R. 1 demands a reduction in the Federal medicaid reimbursement rate by one-third after the first 60 days of general hospital or skilled nursing home care unless the State establishes that it has an effective utilization review program. We certainly agree that this is good, but we do think that the very tight means of establishing utilization review is, as spelled out in the statute, unnecessary.

The association agrees that periodic utilization and medical review of hospital and long-term care are essential, but we do not agree that the specific means of accomplishing these practices should be spelled out. We do believe that the individual States should be permitted to experiment with innovative utilization and medical review programs best suited to their unique situations, such as selected sampling on a significant percentage of medicaid cases.

In New York State, to cite an example, there are now more than 43,000 medicaid patients in more than 630 skilled nursing homes, all

of whom, under this section of H.R. 1 and under existing medicaid rules, must be individually screened annually. Moreover, under H.R. 10604, which became law 2 months ago, more than 24,000 medicaid patients in intermediate care facilities were added to the caseload which must be individually reviewed in this cumbersome manner. At a time when there are pressing shortages in virtually all medical manpower disciplines, we question whether the cost of this bed-by-bed review approach is the wisest use of medicaid program funds.

We further believe that the categorical restrictions placed on mental hospital inpatient care under this section of H.R. 1 are unduly stringent. To reduce Federal medicaid reimbursement by one-third after 90 days and to cut off any degree of Federal aid after 365 days of care in a lifetime will inevitably lead to serious hardship for families of the long-term mentally ill who cannot qualify for other forms of public assistance.

Our second question relates to another feature of section 207, the provision that the Secretary of Health, Education, and Welfare is to compute a reasonable cost differential for reimbursement between skilled nursing homes and intermediate care facilities. We believe this is at odds with the thrust of H.R. 1 toward permitting States a greater latitude in setting medicaid institutional policy.

New York and many other States have pioneered the area of costing and we are loath to see this erosion of prerogatives. We believe that only the individual State is in a position to judge purely local economic, social, and geographic factors which combine to dictate the optimum reimbursement patterns for the available mix of acute and long-term care facilities.

We believe that this provision would deny the States one of the tools most essential to helping them shape the development of their health care systems.

In any event, we do think that it should be amended at least to specifically key the determination of this differential to include both operating and capital costs. If this is not done the capital construction and improvement loan programs operated by New York and other States will be sharply handicapped.

For instance, intermediate care facilities seeking to provide new or improved patient care facilities will be, in effect, penalized for their efforts.

Finally, it should be clearly stated in this section of H.R. 1 that however the differential may be established, the process will take into account regional variations in long-term care facility operating costs.

Now, our third suggestion has to do with section 225 of H.R. 1 which establishes certain limits on payments for skilled nursing homes and intermediate care facilities. Here, H.R. 1 would limit the average per diem costs for these categories of care countable for Federal financial participation to 105 percent of such costs for the same quarter of the preceding year.

As you know, the health care system is subject to national and regional inflationary pressure beyond its control but unlike most other industries, however, health care is subject also to a unique kind of inflation, one dictated in part by revolutionary and costly advances in technology which in turn engender new Federal and State rules aimed at insuring that all health care facilities offer the best possible care.

Because of this phenomenon, controlling the health care industry's inflationary spiral is a most delicate process requiring great flexibility and full understanding of the medical, economic, and social forces.

In New York State where we pioneered in health care cost control and in an increasing number of other States where cost control is already proving successful, we have seen progress only because we have maintained a delicate balance between the encouragement of better quality care and the moderation of costs of that care. Therefore, we strongly urge amendments to the present form of H.R. 1 which would specifically deal with these issues:

First, nonoperational costs: If capital construction or improvement costs are to be calculated into that 5-percent ceiling, the impact on nursing homes and intermediate care facilities throughout the Nation would be catastrophic. Facilities wishing to construct new structures or to renovate existing plants would be effectively barred from doing so. Moreover, States such as New York which have developed health facility loan programs would see their efforts to upgrade health care virtually killed. A flat 5-percent ceiling would have this impact simply because the cost of amortizing construction and mortgage costs in today's economy can constitute from 10 to 20 percent of the per diem rate in a long-term care facility.

Second, concerning employee wages, H.R. 1, as presently constituted excludes only those salary increases mandated under Federal minimum wage legislation from the 105 percent calculation. But in New York and many other States minimum wages well above the Federal standard have been established and are periodically raised. Moreover, many States are in the midst of a period of rapid upward adjustment in health care industry wages. Labor contracts are being signed which are fast propelling hospital and long-term care salaries up to and beyond the general wage levels of other industries. This adjustment is long overdue but it is costing, in many cases, far more than would be permissible under a flat 5-percent inflation ceiling.

Third, improvements in care: A 5-percent limitation on increased costs would also seriously jeopardize continuing improvements in the quality of long-term care which flow from changes in State health care codes and in Federal medicare and medicaid regulations. If the added costs necessitated by essential regulations are to be calculated into that 5-percent limit without exception, many long-term care facilities will be forced out of the medicaid program.

Our fourth principal area of concern relates to section 232 of H.R. 1 which spells out the means of determination of reasonable costs of inpatient hospital services in both the medicaid and the maternal and child health programs.

This section provides that while States will be allowed to develop methods and standards for reimbursing the reasonable costs of medicaid supported inpatient hospital services, such costs cannot exceed medicare rates. Now medicare operates on the premise that the average daily cost for a spell of illness is less for a medicare patient than for a medicaid patient.

Also we have some questions in our statement about the—whether or not the medicaid method of determining costs is the best one and we believe the two should not be tied together at this time.

That summarizes the statement I wish to present to you and I appreciate very much this opportunity of appearing before you.

The CHAIRMAN. Thank you very much.

Are there any questions, gentlemen?

Senator RIBICOFF. I have one, Mr. Chairman.

I am wondering, Dr. Ingraham, at present there are three different HEW agencies involving the standard setting and standards of care for medicare and medicaid. Does this pose any problem for the State having three agencies telling you what you ought to be doing?

Dr. INGRAHAM. Yes; it does. They frequently are contradictory and it does make much greater effort, of course, from our point of view. My association believes that there is a tremendous necessity for combining health agencies in Washington. As a matter of fact, we have proposed that there should be one Department of Health and somewhat facetiously I said it should have just one telephone number precisely for this reason, so that the States would know with whom they must deal and would have uniform regulations and interpretations of regulations.

Senator RIBICOFF. In other words, the Medical Services Administration, the Community Health Services, the Bureau of Health Insurance—ought to be consolidated at least under the Assistant Secretary of Health so there would be one directive going out to the States instead of having three contradictory ones?

Dr. INGRAHAM. It would be very helpful, sir.

Senator RIBICOFF. That is all, Mr. Chairman.

The CHAIRMAN. Any further questions, gentlemen?

Thank you very much, Dr. Ingraham.

Dr. INGRAHAM. Thank you, sir.

(The prepared statement of Dr. Ingraham follows:)

PREPARED STATEMENT OF HOLLIS S. INGRAHAM, M.D.

SUMMARY

1. The Association of State and Territorial Health Officers supports welfare reform provisions of H.R. 1.

2. The Association endorses H.R. 1 provisions which would provide economic and administrative incentives for individual states to improve the quality and availability of health care.

3. The Association urges amendments to strengthen individual states' involvement in administering health care components of H.R. 1 as follows:

A. Permit individual states to determine appropriate means of conducting utilization and medical review of long term care Title XIX (Medicaid) beneficiaries (Section 207);

B. Permit individual states to determine appropriate Title XIX reimbursement differential between skilled nursing homes and intermediate care facilities (Section 207);

C. Exempt certain essential cost increases (capitalization, salary increases and expenses mandated by Federal and state regulations) from five per cent limit on long term care per diem rate inflation (section 225);

D. Permit individual states to set formulae for relating Medicaid to Medicare inpatient hospital rates (Section 232).

Mr. Chairman, members of the Committee. I am Dr. Hollis S. Ingraham, immediate past president of the Association of State and Territorial Health Officers and Commissioner of Health of the State of New York.

The Association which was established in 1942, represents the public health authorities of the 50 states, the District of Columbia, Guam, Puerto Rico, the Trust Territory of the Pacific and the Virgin Islands. Prior to 1942, the leaders of these agencies had met annually since 1902 when the Congress authorized

the United States Surgeon General to convene meetings of state health officers.

As its name and history imply, the Association is intensely interested in any national legislation which impinges upon the common weal of the citizen whose good health we serve and whose best health interests we seek to represent in Washington.

Most of the national debate over H.R. 1 has centered on the welfare reform aspects of this historic legislation, aspects which my Association strongly supports. We believe that a Federal assumption of key public assistance responsibilities would at once stabilize our welfare system and remove an increasingly intolerable financial burden from the larger, urbanized states which now are carrying a disproportionate share of what is, in fact, a common national problem.

However, too little of this debate has focused on a number of major changes that enactment of this statute would wreak on the nation's health care system. It is my purpose today to discuss briefly what some of these changes will mean to the individual states and to point out some provisions of this legislation which my Association believes must be substantively amended if H.R. 1 is to further the cause of sound, accessible health care in America.

The Association applauds the overall thrust of H.R. 1 with respect to its health care provisions. We are particularly hopeful that this legislation, if coupled with a sound national health insurance program, will have a significant stabilizing effect on the revenue sources of our health care system. Such stability would redound to the benefit of all segments of society by permitting more rational planning for, and organization of, health care services.

We further applaud the emphasis that this legislation places on the role of the individual states with respect to implementing many long-needed improvements in the health care system, improvements which have previously been difficult, if not impossible, in some areas of the nation, largely because of uncertain national policy and inadequate national financial support. This legislation would make possible the extension to all areas of the country of several innovative concepts already proven in New York and other major states. These include: truly comprehensive health facility planning; the involvement of public health agencies in actively promoting and reviewing the quality of institutional health care; and the creation and encouragement of pre-paid preventive health care organizations.

Armed with the incentives provided by H.R. 1, all states would be better able to join in speeding the day when all Americans, regardless of economic standing, will have ready access to high quality health care services whenever and wherever they may need them—and at a price this nation can afford.

As my statement must be brief, I will confine my specific comments to four provisions which the Association believes must be re-structured to ensure that the administrative and financial tools provided in this legislation can be most effectively used by the states in accomplishing the objectives of H.R. 1.

The first of our suggested amendments concerns Section 207 wherein a series of incentives are established to encourage the states to emphasize preventive health care under Medicaid.

While the Association strongly supports the intent embodied in these incentives, we fear that several of the disincentives provided in H.R. 1 to discourage prolonged institutional care will, if not amended, cause major problems for the states.

For example, H.R. 1 demands a reduction in the Federal Medicaid reimbursement rate by one-third after the first 60 days of general hospital or skilled nursing home care unless the state establishes that it has an effective utilization review program. At face value, this provision seems unquestionably good. However, rather than establish the principle and permit leeway for its execution, the precise means of utilization review of nursing home services is spelled out in the statute, to wit: each Medicaid patient must be individually reviewed by a professional team whose members are neither directly involved with the care of that patient *nor* employed by or financially interested in any skilled nursing home.

The Association agrees that periodic utilization and medical review of hospital and long term care are essential to ensuring that Medicaid services are properly delivered. But we do not agree that the specific means of accomplishing these practices should be spelled out in this detail in Federal legislation. Rather, we believe that individual states should be permitted to experiment with innovative utilization and medical review programs best suited to their

unique situations such as selecting sampling on a significant percentage of Medicaid cases with application of modern computer technology to determine whether the entire system is working to everyone's best advantage.

In New York State, to cite an example, there are now more than 43,000 Medicaid patients in more than 630 skilled nursing homes, all of whom, under this section of H.R. 1 and under existing Medical rules, must be individually screened annually. Moreover, under H.R. 10604 which became law two months ago, more than 24,000 Medicaid patients in intermediate care facilities were added to the caseload which must be individually reviewed in this cumbersome manner. At a time when there are pressing shortages in virtually all medical manpower disciplines, we question whether the cost of this bed-by-bed review approach is the wisest use of Medicaid program funds.

We further believe that the categorical restrictions placed on mental hospital inpatient care under this section of H.R. 1 are unduly stringent. To reduce Federal Medicaid reimbursement by one-third after 90 days, and to cut off any degree of Federal aid after 365 days of care in a lifetime will inevitably lead to serious hardship for families of the long time mentally ill who cannot qualify for other forms of public assistance.

Our second question relates to another feature of Section 207, the provision that the Secretary of Health, Education and Welfare is to compute a reasonable cost differential for reimbursement between skilled nursing homes and intermediate care facilities.

This provision seems at direct odds with the thrust of H.R. 1 toward permitting states a greater latitude in setting Medicaid institutional reimbursement policy. Were this section consistent with that thrust, the states would determine the proper differential, basing it on the economic realities of their own health care system. New York and many other states have pioneered in this area and we are loathe to see this erosion of our prerogatives. Only the individual state is in a position to judge purely local economic, social and geographic factors which combine to dictate the optimum reimbursement patterns for the available mix of acute and long term care facilities. For the Federal government to pre-empt this function would be to deny the states one of the tools most essential to helping them shape the development of our health care system.

In any event, H.R. 1 should at the very least be amended to specifically key the determination of this differential to include both operating and capital costs. If this is not done, the capital construction and improvement loan programs operated by New York and other states will be sharply handicapped. To cite but one specific impact of this provision if it is not amended: intermediate care facilities seeking to provide new or improved patient care facilities will be, in effect, penalized for their efforts.

Finally, it should be clearly stated in this section of H.R. 1 that however the differential may be established, the process will take into account regional variations in long term care facility operating costs. This provision would be particularly important to large, urbanized states where extensive rural areas surround major urban centers.

Our third objection has to do with section 225 of H.R. 1 which establishes certain limits on payments for skilled nursing homes and intermediate care facilities.

Here, H.R. 1 would limit the average per diem costs for these categories of care countable for Federal financial participation to 105 per cent of such costs for the same quarter of the preceding year.

The health care system, like all other industries, is subject to national and regional inflationary pressures beyond its control. Unlike most other industries, however, health care is subject also to a unique kind of inflation, one dictated in part by revolutionary—and costly—advances in technology which in turn engender new Federal and state rules aimed at ensuring that all health care facilities offer the best possible care, incorporating innovative technology, new classes of medical professionals, new medicines and new treatment methodologies.

Because of this phenomenon, controlling the health care industry's inflationary spiral is a most delicate process requiring great flexibility and full understanding of the medical, economic and social forces working to push medical care costs up.

In New York State, where we have pioneered in health care cost control, and in an increasing number of other states where cost control is already proving successful, we have seen progress only because we have maintained a delicate balance between the encouragement of better quality care and the moderation of costs of that care. The inflexible five per cent inflation ceiling dictated by H.R. 1 could do incalculable damage to that balance.

Therefore, we strongly urge amendments to the present form of H.R. 1 which would specifically deal with these issues:

1. *Non-operational costs.*—If capital construction or improvement costs are to be calculated into that five per cent ceiling, the impact on nursing homes and intermediate care facilities throughout the nation would be catastrophic. Facilities wishing to construct new structures or to renovate existing plants would be effectively barred from doing so. Moreover, states such as New York which have developed health facility loan programs would see their efforts to upgrade health care virtually killed. A flat five per cent ceiling would have this impact simply because the cost of amortizing construction and mortgage costs in today's economy can constitute from 10 to 20 per cent of the per diem rate in a long term care facility.

All states, including New York, bear the responsibility to ensure that all health care facilities are professionally and structurally upgraded to meet at least minimum Federal and state standards. New York and many other states have embarked on massive aid programs designed to make these improvements possible. To underline the potential impact of a flat five per cent inflation ceiling on not only government but also private capitalization programs, I will detail some of the experience New York has had over the past several years.

In 1966, when the New York State Department of Health assumed comprehensive health facility "franchising" powers, we had 42,500 long term care beds in operation, with fully half of these failing to meet current Federal and state standards. Today, we have over 69,000 long term care beds in use, with only 11 per cent of these under applicable standards to any substantial degree. Moreover, we have an additional 47,000 beds either under construction or planned to be built by 1975, a number which will greatly expand our long term care capacity and enable us to phase out existing substandard facilities over the next several years.

Obviously, this progress in meeting New York State's long term care needs has been costly. For the State, it has meant the commitment of almost \$1 billion out of health facility mortgage loan programs of \$4.7 billions, to provide a means of financing non-profit and public nursing homes and intermediate care facilities. Also since 1966, private capitalization in New York State has financed hundreds of millions of dollars of long term care facility construction and renovation.

The medical need for this massive infusion of capital is undeniable. But repaying that capital—a process which can be reflected in 10 to 20 per cent of a long term care facility's per diem rate over 30 to 40 years—is unavoidable. To deny these costs through imposition of an arbitrary per diem inflation ceiling would yield only a short term, show-case financial saving. In the long view, such a policy would result only in an unacceptable disservice to the medical needs of our long term care population.

Unless H.R. 1 is amended specifically to exclude construction costs from that five per cent ceiling, our health care system could face a dilemma of insoluble proportions. Nursing homes and intermediate care facilities would have to choose between shifting these costs to non-Medicaid patients, who comprise only 30 per cent of some states' long term care patient populations, or eventually close their doors to up to 70 per cent of those needing long term care.

2. *Employee wages.*—H.R. 1, as presently constituted, excludes only those salary increases mandated under Federal minimum wage legislation from the 105 per cent calculation. But in New York and many other states, minimum wages well above the Federal standard have been established and are periodically raised. Moreover, many states are in the midst of a period of rapid upward adjustment in health care industry wages. Labor contracts are being signed which are fast propelling hospital and long term care salaries up to and beyond the general wage levels of other industries. This adjustment is long overdue—but it is costing, in many cases, far more than would be permissible under a flat five per cent inflation ceiling.

3. *Improvements in care.*—A five per cent limitation on increased costs would also seriously jeopardize continuing improvements in the quality of long term care which flow from changes in state health care codes and in Federal Medicare and Medicaid regulations. If the added costs necessitated by essential regulations are to be calculated into that five per cent limit without exception, many long term care facilities will be forced out of the Medicaid program—and perhaps out of business altogether.

Our fourth principal area of concern relates to section 232 of H.R. 1 which spells out the means of determination of reasonable costs of inpatient hospital

services under both the Medicaid and the Maternal and Child Health programs. This section provides that while states will be allowed to develop methods and standards for reimbursing the reasonable costs of Medicaid-supported inpatient hospital services, such costs cannot exceed Medicare rates.

This provision if enacted without amendment, will generate a tremendous accounting dilemma for all states in that it is impossible to equate Medicare and Medicaid service costs. Medicare operates on the premise that the average daily cost for a spell of illness is less for a Medicare patient than for a Medicaid patient. This disparity results from the actuarial fact that the Medicare patient, due to age and general physical condition, is hospitalized longer for a given illness than is his younger Medicaid counterpart.

If Medicaid rates must be equated with Medicare rates, it will be necessary for each state to subject each individual medical service offered by each hospital to the complex Ratio of Cost to Charges (RCC) process mandated by Federal rules. The effect of this process on this nation's more than 6,000 hospitals will be tremendous. And particularly tragic would be the inflationary impact on services provided to non-Medicaid-Medicare eligibles as the hospitals would be forced to look elsewhere to make up Medicaid deficits. Patients with indemnity-type health insurance coverage would suffer the most as their limited health care dollars would be eroded.

Rather than establish this impossible equation in Federal law, we strongly urge that H.R. 1 be amended to permit the states to set their own formulae for relating Medicaid to Medicare rates.

We in the states and territories are more than eager to work with Washington toward remedying the lingering ills of the nation's health care system. We ask only that the Congress heed our plea and make the individual states truly creative partners, rather than sidewalk superintendents, in this most critical national task.

The CHAIRMAN. The next witness is Mr. Jeffery Cohelan, executive director of the Group Health Association of America, Inc., accompanied by Dr. W. Palmer Dearing.

**STATEMENT OF JEFFERY COHELAN, EXECUTIVE DIRECTOR,
GROUP HEALTH ASSOCIATION OF AMERICA; ACCOMPANIED BY
W. PALMER DEARING, M.D., MEDICAL CONSULTANT, GHAA**

Mr. COHELAN. Mr. Chairman, my name is Jeffery Cohelan. I am the executive director of Group Health Association of America. GHAA is the national association representing the major community and consumer-oriented prepaid group practice plans in the United States and Canada. Our affiliated plans are responsible for the health care of 4 million people and in addition GHAA is the recipient of a Federal grant for the purpose of organizing prepaid group practice plans in some 33 cities over the next few years. Currently we are active in some 20 cities where our type of health maintenance organizations are in various stages of development.

I am accompanied this morning, Mr. Chairman, by W. Palmer Dearing, M.D., medical consultant to GHAA and my immediate predecessor. Dr. Dearing served as executive director for 10 years and before that was the Deputy Surgeon General of the U.S. Public Health Service. He is particularly qualified to speak on the subject of our interest in this legislation.

Mr. Chairman, you may recall that GHAA appeared before this committee on April 25, 1971, during the hearings on various national health insurance proposals. At that time we addressed ourselves in a general fashion to the health maintenance organizations concept in the context of our experience and expertise with regard to prepaid group practice plans. We discussed, you will remember, the benefits which

a well-structured health maintenance organization could offer as an alternative form of health care delivery and set forth some of the difficulties and expense involved in their creation. We recommend specific guidelines for those who seek to organize and those who seek to regulate health maintenance organizations. We will not take the time of the committee this morning to reiterate that testimony. We will confine ourselves to the existing health maintenance organizations provisions of H.R. 1. We also have some comments on catastrophic health insurance and the peer review amendments in the event the committee considers adding these to the bill.

The health maintenance organizations provisions of H.R. 1 will be the first major legislative input into the health maintenance organizations concept and will have an important impact on the national health policy. Thus in its work on the health maintenance organizations provisions of H.R. 1 this committee has an important opportunity to improve the chances for financially sound and well-structured health maintenance organizations.

Ultimately, we hope that providing medicare benefits through prepayment to health maintenance organizations will result in medicare beneficiaries constituting a substantial membership base in health maintenance organizations.

But we do not expect any appreciable immediate increase in health maintenance organizations membership until some time has elapsed after the enactment and implementation of these provisions. Rather, we think there will be a slow but steady growth of medicare beneficiaries in health maintenance organizations which will somewhat parallel the growth and acceptability of health maintenance organizations by the public as a whole. Medicare beneficiaries will be reluctant to change traditional patterns of health care simply because an alternative system has been made available to them. The small number of existing health maintenance organizations in the country available for immediate enrollment will likewise limit growth.

I turn now to catastrophic insurance, Mr. Chairman and members of the committee, and I would like to comment on one proposal to help solve the Nation's health care crisis which has attracted considerable support among some segments of the health industry and public which would seriously affect prepaid group practice plans. This is the proposal to initiate a federally sponsored program of major medical or catastrophic illness as the next step toward meeting the Nation's recognized health needs.

Group Health Association of America recognizes, expensive, long-term illnesses. Our association would not oppose any effective measure for dealing with this problem.

We urge this committee to recognize, however, that catastrophic coverage is no substitute for comprehensive health coverage. Moreover, emphasis on catastrophic coverage right now would almost certainly undermine efforts long overdue and now underway to give proper emphasis to primary care and ambulatory services. New emphasis on major illness would most certainly distort the allocation of national health care resources, turning them again toward hospitalization and other institutional treatment and away from prevention, home care, and other neglected aspects of health care.

All the catastrophic coverage proposals share the fundamental idea that insurance should take over only after a family has paid hundreds or even thousands of dollars for medical expenses.

Experts in health care economics who do not come from the vested interests in the field tell us that national insurance limited to catastrophic coverage would accelerate the current inflation of health care costs. Also, we have had sufficient experience in the years of medicare to realize that providers will be motivated to raise their prices so that a family or individual can become eligible for catastrophic benefits. The net result would certainly be a further boost in charges for all aspects of health.

Other testimony before this distinguished committee, notably that of the AFL-CIO and the National Council of Senior Citizens, has gone much more into detail with respect to the disastrous push toward further inflation and the distortion of priorities in deployment and use of our health resources that would result from a separate catastrophic illness insurance program.

If, however, catastrophic illness or major medical insurance were to be enacted as a special benefit in whatever context, special provisions must be made for group practice plans if they and their subscribers are not be seriously disadvantaged and overcharged.

The comprehensive benefits of group practice plans include de facto major medical benefits in their regular contracts. Whereas, major medical coverage added upon typical commercial and Blue Cross-Blue Shield contracts would cost \$4 to \$4.50 per month, the supplemental coverage added to a group practice plan benefit would cost in the neighborhood of \$1 to \$1.50 per month. A single national premium charging indemnity insurance rates would take about \$3 per month from the group practice plan subscribers.

Therefore, a catastrophic program based on cost reimbursement or premium subsidy after large deductibles make the value of the catastrophic override worth much less to members of a prepaid group practice than to other health plans. Further, prepaid group practice plans are built upon incentives for minimal hospitalization and preventive health care. It would seriously diminish the effectiveness of prepaid group practice plans in the health care market if these differences were ignored.

In order to assure the members of our plans equitable treatment if a catastrophic health insurance program along the lines of S. 1376 is enacted, there should be provision for prepayment to group practice plans on behalf of their members from the program. The prepayment should equitably relate to payments from the program in the nonprepaid group practice area. This prepaid premium from the Federal program should take into account the cost of care in the geographic area where the plans operate.

Furthermore, the prepaid premium should be integrated into the regular pay structure of our plans. Such a prepaid premium under a catastrophic health insurance program will help to preserve the equitable position of our members to that of members of other plans.

Prepaid group practices should not be required to cover all of the services involved to the extent of the deductible under the catastrophic program. This could cause diversion of the plan resources from higher

priority services or might mean a further burden in the form of rate increases on our members. This is especially true in the case of smaller plans where such coverage has a greater actuarial impact.

At this point, Mr. Chairman, I submit for the record some suggested language amending S. 1376 incorporating the foregoing.

I am on page 9 and I quote:

Section 2004(a) (4). In the case of an organization which provides or arranges comprehensive health care services for a defined population, the Secretary shall authorize per capita payments to such an organization on behalf of eligible individuals enrolled in such organizations. A combined per capita payment may be made to such organizations for the services set forth in subsections 2004(a) (3), which are provided or arranged by such organizations. Such per capita payments shall equal the average payments made on behalf of eligible individuals residing in the general geographic area served by such an organization and shall be based upon the undertaking by such organizations or arrange services to eligible individuals enrolled in such organizations and shall not be based upon specific services rendered to each eligible individual.

Finally, Mr. Chairman and members of the committee, we have some comments on the amendment introduced by Senator Bennett on January 25, 1972, dealing with professional standards review organizations.

Our main concern with the peer review proposal from its inception stemmed from review of prepaid group practice operations and procedures by physicians whose orientation has in the main been outside a prepaid group practice setting. We were less concerned about the historical antagonism of the professional societies to our system of health delivery than we were about the lack of complete understanding by most physicians of the complexities of our system.

Prepaid group practices have always had intrinsic peer review objectively rendered. It is the objectivity of peer review that has always given us pause. We felt it would be difficult to establish by statute a system of peer review which would be free from bias and rendered with a full understanding of our operation.

Also, Mr. Chairman, we have some concern with the authorization and, indeed, the encouragement for PSRO's to go into the insurance business through risk-sharing as provided in section 1170 of Senator Bennett's amendment. This would seem to make possible a whole chain of insuring organizations which were also carrying out PSRO functions, but without any of the standards and controls so elaborately provided for with respect to health maintenance organizations.

Also, whether or not PSRO's can also appropriately undertake risk for the services they are supposed to monitor would seem to us questionable.

Mr. Chairman and members of this distinguished committee, this concludes our statement and we, of course, would be most pleased to respond to any questions that you might have.

The CHAIRMAN. Well, I am curious to know how you feel that catastrophic insurance is going to distort the use of medical resources. My impression is that in these catastrophic cases you either provide the care or the person dies.

Now, the services are currently being provided. However, the families have all their resources wiped out, and they are heavily in debt for many years to come.

Now, where does that distort the use of services? The services are being provided. It is just that the resources of the people have been

wiped out and they are very deeply and hopelessly in debt for many years to come.

Are you suggesting that in instances of catastrophic illness we just let them die?

Mr. COHELAN. No. On the contrary, Senator, as I am sure you would recognize, we are very deeply dedicated to the idea of improvement and expansion of our health care services in this country and to meet some of the desperate needs that this committee is studying.

We do, however, feel that in relation to some of the things that are going on—for example, health maintenance organizations and this general conception which speaks to the question of providing health care services and perhaps the use of resources more efficiently, that to concentrate on this particular item in relation to these other things could possibly drain away very valuable resources.

But, more importantly, we feel that if the committee is disposed to enact such legislation, they do so with some understanding that this should not detract from these other objectives that are contained in the measures now before us, and that it also be recognized that it should not be in conflict with the purposes of a health maintenance organization and that you recognize there is a very significant difference in the fee for service systems for health delivery and the prepayment system of health delivery.

The CHAIRMAN. Of course, I am for ambulatory services, and we will be doing more about that as time goes by. But my theory of insurance is that you ought to insure yourself first from the risk that you cannot afford to take.

Now, we care for the poor, under medicaid. We will probably provide more care and that is going to cost a lot of money.

We are putting about another \$1.5 billion in this bill through medicare for the disabled.

Now, if you are not poor and you therefore do not qualify as a medical indigent, you should be able to pay out, especially if you take, as many families do, a few months to pay for it—you might be able to pay a \$200 or \$300 medical bill, but that is not what you need the insurance for. What you need the insurance for is this type thing which comes about once in a lifetime which can just completely wipe out everything you have.

Senator CURTIS. Would you yield?

Does your plan take care of catastrophic cases?

Mr. COHELAN. Most of our plans provide for very comprehensive coverage.

Dr. Dearing, would you care to comment?

Senator CURTIS. I didn't mean to take his time; I just wanted to know, do you have a ceiling or don't you?

Mr. COHELAN. There are certainly limits, but we provide very generously in our comprehensive coverage.

Senator CURTIS. I don't want to take the time.

Dr. DEARING. The group practice plans generally provide a great proportion of catastrophic coverage and the figures which Mr. CoheLAN gave in his testimony of the rates are actual figures from the California Kaiser experience, in which some of their insured groups have, by collective bargaining, a catastrophic override which they are required

to take and which the employer or somebody pays for; and this prices out to about \$4.50, whereas the cost of the added services to the—above the Kaiser services is only about \$1, so let's say they provide three-quarters of what these going catastrophic coverages now in existence in the private market cost.

Senator CURTIS. Excuse me, Mr. Chairman. I didn't mean to interrupt.

Mr. COHELAN. Mr. Chairman, this would be the measure of the difference, in response to the Senator's question. We do cover just about everything.

Senator CURTIS. Just about, but you don't tell your people you take care of everything that happens?

Mr. COHELAN. No, indeed, not quite, but we would add to that, Senator; this is the point. We would think that the catastrophic concept should be cared for in a concept of comprehensive health care.

The CHAIRMAN. Then you want me to vote for the Kennedy bill, I take—it that is, the national health insurance bill?

Mr. COHELAN. This is not the issue before us at this time.

There are many of our members, Senator, who are very actively in support of it. However, that is not true of all our members. There is a different view of that in terms of priorities in our own organization so I am not prepared to, at this time, advise you on how we would hope you might vote on some other issue. But I would think in respect to the matters that are before you now, it is highly relevant to our concerns and common interest and it has to do with the effect of any legislation that might be drafted by this distinguished committee on the existing health maintenance organizations arrangements or those that are prospective, that we are setting up, and we are proposing the health maintenance organization option subject to approval of this committee.

If we, on the one hand, pass legislation that is going to inhibit the development of this pattern of health care delivery it would, I think you might agree, be a mistake or at least it should be guarded against and we have suggested two things: We have suggested, on the one hand, that this might distract from primary comprehensive health matters. But if you do move in this direction, Senator, we would hope that you would not inhibit the existing health maintenance organizations or those about to be formed by recognizing the difference—the \$1 to \$1.50 as opposed to the \$4.50.

The CHAIRMAN. That is fine. I am happy to recognize that and try to incorporate that feature.

I have paid a lot of medical expenses in my lifetime, not only for myself but for relatives, even to help pay a friend's medical bills on occasion, and I am familiar with these catastrophic situations. I have seen people who are either dear to me or dear to someone who in turn was dear to me, have all their resources wiped out.

It is pretty disappointing for people to have everything they had, wiped out, and that is what the insurance principle, is supposed to protect against.

Mr. COHELAN. Well, so far as insurance and the concept of insurance, Senator, the concept as I understand it is to spread the risk; and what we found in the health field is that this system of experience

rating and all the rest is a combination of highly selective risks and as a result we get all kinds of distortions in terms of this broad concept of risk-taking.

When you look at the health care delivery system that we are talking about, we are not delivering dollars; we contract to provide services and this is a very important difference. We provide a set of comprehensive health services and we do not pay out dollars. In fact, I think the record will show that one of the great difficulties in the health care delivery field with cost reimbursement formulas of one sort or another is that they have been very inflationary because we are dealing with dollars; we are not dealing with the offering of services.

When you contract for one of the major programs in our country—HIP in New York, the Kaiser Foundation Health Plan, the Group Health Cooperative of Puget Sound which is the first one to occur of about some 20 odd throughout the country that are of major significance and importance—you contract for services and, of course, what we are pointing out in reference to catastrophic is that most members of most plans would be pretty well covered on a very serious long-term illness.

The CHAIRMAN. That is in your group health plans?

Mr. COHELAN. That's right, sir, and that is the point. But if you move into the direction of catastrophic we think it is vitally important that you recognize that the difference between the indemnity program and the provision of care program should be taken into account, and that we ought to be allowed to make certain adjustments, for example, in the form of increased benefits.

We can increase—

The CHAIRMAN. Let me ask you this: You are taking care of a great deal of catastrophic illness with group health, but how about the people who are not in group health plans, aren't they in a pretty bad situation with regard to the catastrophic illnesses?

Mr. COHELAN. Well, Senator, one of the things we perceive on the basis of matters that are being considered at this session of Congress is this very question. What you are discussing is the question of how you finance medical care.

Now, to be sure, most prepaid group practice plans are available for people of a certain level of disposable income but one of the things that is developing in the matter that is now before you. H.R. 1, is the question of providing an option for over 65 for a health maintenance organization. There is reason to believe and I think the record will show there is great advantage and there will be savings in costs to the Government that could flow from this. It certainly has to be tested.

On the other hand, there is other legislation pending. The administration, of course, has a bill before you, the Health Maintenance Organization Assistance Act. There is legislation pending in this honorable body as well as on the other side and it is all addressing itself to the question of the organization and the standards for a health maintenance organization; but also it is speaking to the question of how the low-income groups could possibly be handled in this configuration of care and the question is simply one of financing. Either it comes from

the productive process generally or it would come from income transfers from Government and it is perfectly feasible and, in fact, many of our programs under pilot programs now are caring for the low-income groups by contract with the Federal Government.

In Portland, Oreg., and in Seattle they have very excellent experimental programs where they have about 9,000 individuals who are selected from the OEO population and they are caring for them and caring for them quite beautifully.

The same thing is true in other areas throughout the United States. As a matter of fact, right here in Washington there is such a program with the existing Group Health Association of Washington which is the operating plan as opposed to the organization that I represent. But the point is, Senator, that the low-income population, and the income transfer populations, the income maintenance populations, could conceivably work into a configuration of health maintenance organization care.

The CHAIRMAN. Thank you very much.

Senator BENNETT. Mr. Chairman, I have a couple of questions.

On the last page of your statement, you are very critical or a little critical of the proposed PSRO program. You say prepaid group practices have always had intrinsic peer review objectively rendered.

I have underlined "objectively rendered." Are you afraid to have someone else come in and look at your objectivity?

Mr. COHELAN. No. On the contrary, Senator, as the Senator well knows, there has been a long history of hostility to the organization of prepaid group practice programs and some of it is the result of misunderstanding or just simply a lack of understanding on what the general thrust in the quality of a group practice was. Many physicians simply don't like group practice and, by the way—

Senator BENNETT. So you are saying that the private physicians are hypocrites, they are biased, they cannot recognize good medical practice if it is practiced by a group and, therefore, you want to be protected—

Mr. COHELAN. Senator—

Senator BENNETT (continuing). From inspection by them?

Mr. COHELAN. Senator, if I could respectfully suggest, we think no such thing, sir. We are most respectful and most admiring of physicians. As a matter of fact, we hold generally to the view that has been advanced by the distinguished Professor Somers of Princeton University when he says no matter what health care delivery system we have, sir, we must have grunted doctors as opposed to disgruntled doctors.

Your question is somewhat technical and I would like to ask, with your permission, my colleague, Dr. Dearing, to respond to your question because he is a physician.

Senator BENNETT. Before Dr. Dearing talks, let me ask another question or two of you.

Do you know enough about the whole PSRO program, enough to know if there is a PSRO review group formed in an area where there are HMO's, that the doctors who practice in the HMO's are expected to participate in the PSRO review?

Mr. COHELAN. I would be very pleased to hear that.

Senator BENNETT. Did not you know it?

Mr. COHELAN. Well, I now know it.

Senator BENNETT. Well, in other words, you have not read the PSRO amendment very carefully to realize that that is a very essential part of it.

Did you also know that under the program—well, first, let me say that the theory of the PSRO group is that it rotates: there is no single appointment of people who are going to check every program and in the course of the rotation we have what I would consider to be an educational opportunity both for doctors in HMO's and doctors outside of HMO's crossing lines into the other fellow's business. Did you know that under the proposal the PSRO group, if it is satisfied with the objectivity of the review, in-house review, either in a hospital or in HMO can accept that review and not charge itself with attempting to duplicate it?

Mr. COHELAN. Senator, with all due regard, I know that you feel this way about the program and that you have been very active in sponsoring this and for the highest motives.

The problem, sir, is that in examining the question and in studying it, I have learned from many physicians that the concept of peer review is a very difficult one. I have been told that one of the major difficulties is at the very beginning you start reviewing what is called normative behavior. One physician explained this to me in some detail. It seems we often are merely reviewing in many cases a lot of poor practices. Whether or not this is going to yield what all of us would hope for is doubtful.

We may be setting up an elaborate structure that is going to miss the target.

But, more practically—

Senator BENNETT. Have you taken the opportunity, before you came here, to check the experiment that has just been performed in New Mexico?

Mr. COHELAN. No, sir; I am not aware of that. Perhaps Dr. Dearing may have some familiarity with that and, again, I would say, I would prefer that Dr. Dearing respond to this question because essentially it is a medical organization question.

Senator BENNETT. May I say one other thing to you?

The cost of medical care has skyrocketed; the expenses, particularly in medicare, have risen so fast that there is not any question but we must develop some kind of a mechanism to review and control it.

Now, it is my feeling that doctors are the only ones who should be allowed to review the work of doctors; but if the PSRO idea fails, then you are going to have possibly the Department of HEW selecting people who will review it or you are going to have clerks in the insurance groups reviewing it; and I think you had better be a little careful if you are going to reject it simply because—

Mr. COHELAN. Senator, in terms of—

Senator BENNETT. May I talk, please?

Mr. COHELAN. Excuse me, sir.

Senator BENNETT. I think you need to be a little careful if you are going to reject it simply because the doctors in HMO's do not like the doctors outside of HMO's.

Mr. COHELAN. Senator, I think the main point I am making as an executive director and as a nonphysician is simply this is a problem that I think the committee should take official notice of because it is a reality; it has existed over time.

Now, as far as the medical organization question is concerned, I would like to defer to Dr. Dearing.

Senator BENNETT. May I say, before Dr. Dearing talks, that we have changed the text of the bill considerably to try to protect against the fear that you have. Now, probably you haven't had time or an opportunity to read the text but—

Senator ANDERSON. I want some comments on the New Mexico plan you were talking about.

Senator BENNETT. I understand tomorrow we will have a witness who will talk about it. But, in a word, a PSRO group was formed in New Mexico where they only have 800 physicians and they have reviewed the entire medical structure of New Mexico as it affects medicaid—provided by the State and, as I understand it, they are now willing to say—the results have been so good that they are now considering recommending to the State government of New Mexico that they remove all limitation on health care services on the basis of what they found and what they have been able to accomplish.

Now, you also said in your statement, which is not a part of your written statement, that you objected to section 1170 in the bill because it would permit the Secretary to turn over to the PSRO group the review and payment of claims.

You did not read that this gives the Secretary the right to have a demonstration of that program if he wishes? It is not a part of the law. It does not turn this process over to the insurance companies; and if you object to the checking of the feasibility of a relationship between insurance companies and PSRO, would you object to the bill requiring that we have a feasibility study of the combination of insurance and review in HMO's? You have been doing it but I am not sure we understand exactly how successful it has been. Maybe we had better check that.

Mr. COHELAN. Well, Senator, in the first place, let me say, sir, that you will note in my statement I say we express some concern and we are pointing up what we conceive to be a problem, and if the problem is being ameliorated as you describe I would say this was a very happy development.

The other thing is in relation to New Mexico's program, I think this is a salutary development. As a matter of fact, it goes right to the heart of many changes that are taking place throughout our country at this time as the result of the health care crisis and because of the attention of this committee and other committees of the Congress. But I would say, sir, that it is a sad fact that some of this is coming rather late and coming because of the surveillance of congressional committees about the situation.

In relation to prepaid group practice plans in, say, California, for example, one of the very happy developments that occurred in relation to this setting for the provision of medical care was the development of the San Joaquin Medical Foundation which is a provider-controlled operation and which is serving quite beautifully in that area; but the point to this sort of development is that the existence of our other pro-

grams has helped to upgrade medical services throughout our State and in other States throughout the West.

Seantor BENNETT. Well, I will just ask you one final question: Are you putting your organization in opposition to this section or are you just suggesting that maybe we should look at it a little more carefully?

Mr. COHELAN. We are doing two things: We are entering reservations to the PSRO section, Senator, and we are calling attention to what we regard as some defects as it is presently drafted; and I would like to have Dr. Dearing—

Senator BENNETT. You have not seen the latest draft?

Mr. COHELAN. I have it in my brief case.

Senator BENNETT. O.K.

Mr. COHELAN. May I ask Dr. Dearing to comment?

Dr. DEARING. Well, Senator Bennett, I believe, in response to your last question, that I would emphasize what the director just said. We are noting some potentials and ideas. I would put it in terms that we believe, if this were to pass as enacted, the administration—Secretary of HEW and those who carry on and administer the program, monitor it, judge its effectiveness organization by organization, PSRO by PSRO—need to be mindful of some of this history which gives us concern.

Now, with respect to the New Mexico program, I think this is a fine example—as I understand it and have heard reports on it—of what can be done. At the same time the discussions we hear among the profession around the country who admittedly did not understand and have not read, and some are even fearful of all the controls and the administrative machinery that it will take to administer and monitor this PSRO program, we have some fear that some places there will be bias and even malice.

Although the amendment—your amendment—enjoins against this, to try to get this into effect all over the country in a very short time, it will be a monstrous administrative task and it may be that some of our people could get hurt before the 2 years, let's say, that it might take for administration to catch up with all the local PSOR's that will be operated.

This is really more an expression of concern and a caveat, rather than any objection to the principle and of the objectives. We well know that there is a great need for it.

Senator BENNETT. It seems to me it would be a little hard for you to object to the program when you say that you already conduct the process inside your own organizations, and we face a problem. As I say, the costs have gone up so high some method of control must be instituted. If we don't let the physicians operate through the PSOR's, then we are either going to have a bureaucrat or an employee of the carriers—and I am sure the physicians would feel much worse about that than they would about having another physician looking over their shoulder.

Dr. DEARING. I understand in New Mexico physicians who have been working on this have been really quite excited about what they have been able to accomplish in upgrading the professional practice simply by the opportunity to review the claims.

With respect to section 1107, the claims payment—

Senator BENNETT. Wait a minute. The New Mexico physicians did not review the claims in the sense you are talking about money. They reviewed the medical practice.

Dr. DEARING. I understand.

Senator BENNETT. OK.

Dr. DEARING. Our question about section 1107 is not with respect to the claims review, which is the way into the system, and then the opportunity, then, to see what goes on after the fact if they have not done prior review of the procedure. It is the matter of the risk sharing which, as we understand it, is an insurance function as distinguished from the review and the approval of procedures.

Senator BENNETT. Well, of course, there have been a number of variations of the idea of peer review and the carriers would like very much to put the carriers between the Federal Government and the reviewers and, therefore, we feel that it may be necessary to conduct some experiments to find out where best the carriers may fit into this pattern.

Personally, I think the review should be conducted outside of any control or regulation by the carriers and should be conducted by the physicians related to the department directly rather than related to the department through the carriers.

Mr. COHELAN. Senator, I would just comment as far as our prepaid group practice programs that now exist are concerned and hopefully those that are about to be formed, the concept of the autonomous physician group is a most important component of our conception and of our teaching about how to put together a prepaid group practice program and this autonomy includes internal review, medical records; and so forth, in fact, one of the major advances of group practice as opposed to solo practice is the fact there is this more or less constant review of one's work.

Senator BENNETT. Of course, as I said at the very beginning, if your doctors are serving in the PSRO group you preserve that autonomy in part and you may eventually break down the bias or thought of bias that exists.

I was just going to say you know there are many doctors who were as disturbed at the effect of HMO's on their practice as the HMO doctors apparently are disturbed at the prospect of review by outside doctors on their work.

Mr. COHELAN. Precisely, and, Senator, as we indicated before this distinguished committee on other occasions, our general approach to all of these matters is one of pluralism. We suggest—all that we are suggesting in our proselytizing, if you will, for the prepaid mode of care delivery is to give the American people this health alternative as an option.

As the good Senator knows, in many States in our country we still can't organize a health care system on this basis and the reason that we are so concerned as it relates to peer review is there are these lingering hostilities and we would not want to see this attitude further hinder the development of a healthy health care delivery alternative in the form of a health maintenance organization.

Senator BENNETT. We have an overriding problem which is the tremendous increase of the cost to the Government of providing the

health care that the law says we must give to our people and we can't ignore that simply because doctors who work in HMO's are suspicious of doctors who work outside.

Our solution is a kind of pluralism or maybe it is the other way; we put the two of them together in the PSRO groups and let them participate in the review of each other's type of practice.

Mr. COHELAN. Well, Senator, we would feel it very important for you, as a legislative body, and such an important committee dealing with this subject matter to be highly sensitive to the matter that we raise as an issue. It could affect the quality of the program.

As to peer review generally, in my 13 months out of public office and on this particular job, I have been undergoing a very intensive study of what this is all about, although I was not without some experience before I came on this job. The questions that the Senator is raising by his peer review program are questions that are being studied most carefully throughout the country.

It was my privilege only a month ago or several weeks ago to be in New Orleans with Dr. Elwood's group where the whole question of quality care was being discussed in reference to the configuration of health maintenance organizations, but it also had relevance to the entire system, measures that would be acceptable for the determination. It was framed in a health outcomes context in this particular brainstorming session. So I just want the Senator to know so far as I am concerned, currently representing GHAA, we are most sensitive to the problem but we think it quite proper to bring to the attention of this distinguished committee our concerns because we want any such system to work.

Senator BENNETT. I have no further questions.

Senator ANDERSON (presiding). Senator Curtis?

Senator CURTIS. How does the group health plan work in a rural area?

Mr. COHELAN. Well, Senator, in a rural area we have time-distance problems and while it is thoroughly possible to work one, there are some very serious problems in terms of the components.

In order to put together a viable health maintenance organization, we at GHAA are pointing out that it takes from about 20,000 individuals to 50,000 individuals in enrolled population to support a group of, say, 10 full-time physicians; so clearly in sparsely settled areas it is difficult.

Senator CURTIS. Give me those figures again.

Mr. COHELAN. It takes about 20,000 enrolled members, individuals, in order to sustain a viable HMO program or prepaid group practice program and if the Senator will use, say, \$45 a month for a family of four or as high as, say \$60 a month for a family of four, and with a quick calculation you can see what it will yield and roughly give you what you have to finance and what you have to pay your mix physicians and specialists.

The Kaiser Foundation says it takes about 50,000 before you can get to even a breakeven point.

Senator CURTIS. 50,000 members?

Mr. COHELAN. Yes, sir.

Senator CURTIS. Of course, it is not compulsory?

Mr. COHELAN. No, sir; the essential components—

Senator CURTIS. How much population do you need to get 20,000 or 50,000 members?

Mr. COHELAN. What those ratios would be escape me at the moment. The real problem is to have a large enough population to enroll sufficient members to generate your program. What is conceived of by current development programs, Senator, feasibility studies are first made; we in GHAA and others are invited to come into the community and help organize such a program but clearly it is a function of population, of the state of the economy, the employment patterns, the productivity, and so on because primarily it is targeted for disposable income population. Do I make myself clear?

Senator CURTIS. Yes; to make 20,000 members would you need twice that population?

Mr. COHELAN. I would think even more than that, Senator. I think you would have to have a much larger group.

Senator CURTIS. So what you are proposing really, isn't something for the farm and ranch country?

Mr. COHELAN. I would not say that it was impossible but I would think the arrangements would be different and would have to cover a larger area. For example, it is conceivable to have a health maintenance organization in the State of Nevada. It would be conceivable to have one in other population areas that were—where there was a distance problem, but you would have to work it out on a different basis and you would certainly have to have some method of medical evacuation, as it were, to get the people to the center.

Senator CURTIS. If your group practice does not take care of catastrophic cases without any setting of a ceiling or limit, what is the ceiling?

Mr. COHELAN. Dr. Dearing can you provide that data?

Dr. DEARING. Well, Senator Curtis, the plan—some plans have no ceiling at all on hospitalization, continuing hospitalization, as much as needed, 365 days a year. That is pretty near full coverage.

Senator CURTIS. How many years?

Dr. DEARING. Pardon?

Senator CURTIS. How many years?

Dr. DEARING. Indefinite; some for 1 year. but some plans—and I believe GHA here in Washington has no limit on—no limit at all—HIP has 1 year and this takes care of the vast majority of the catastrophic. Kaiser's have limitations on about 4 months fully paid and another 4 months, say, at half pay; but as I described earlier, their override takes care of financially about three-quarters of the general category.

Senator CURTIS. I suppose that small percentage that are not taken care of are of concern of the Congress?

Dr. DEARING. Indeed so.

Senator CURTIS. Because I visited a while back a husband, where the wife was ill; neither one of them were 25 years old and they faced a hospital bill just of a few weeks that amounted to \$30,000.

Dr. DEARING. Yes, sir.

Senator CURTIS. Now, to my mind that is catastrophic. I am not quite in accord with my chairman's definition of catastrophic. Cata-

strophic to me is something that just reaches outer limits. It can't be done. It is not—every high cost illness is definitely not catastrophic. It may be that \$30,000 would be catastrophic for most people but it shouldn't be to someone who makes that much money in 1 year. But the people who enroll in your setups they are not taken care of regardless of how much of a burden they might face?

Dr. DEARING. Most have a high ceiling on hospitalization. The medical services—the doctor services are generally unlimited.

Senator CURTIS. Well, of course, the big cost of medical care is the hospital. The doctors' fees are percentagewise—

Mr. COHELAN. Senator, what the doctor is saying, most of our plans are noted for the fact, sir, that they cover comprehensively both inpatient and outpatient full hospitalization in several of the cases and with exception in some of the cases. May I say to the Senator that the packages will vary depending upon the need of the individual and in some of our plans why there are several forms of services that are provided which would be a function of the premium or the dues as we call it, membership dues, that you are able to pay; and the quotations that I have been making have been of the optimum which would be a family of four and these general ranges of expenditures for these services, these health services.

Senator CURTIS. How old is this system?

Mr. COHELAN. I would say that—Dr. Dearing—it goes back to the turn of the century, does it not, with the railroads, but I think the significant date would be 1945.

Dr. DEARING. It is earlier than that. The group plans started in the depression and even predepression. I believe the Ross-Loos plan in Los Angeles started about in 1930 and the Kaiser plans were in being in the late 1930's in construction work and then into the war, where they developed their full potential while serving an industrial population.

Senator CURTIS. In the 25 or 30 years it has been operating, what is the smallest community you now have?

Dr. DEARING. Two Harbors, Minn., I think. They have had about 5,000 enrollees, it is up there at the foot of the Iron Range above Duluth on Lake Superior and it has continued; it is mixed; they have some fee-for-service patients and they also have an enrolled population.

Senator BENNETT. How big is the town?

Dr. DEARING. I don't remember; a few thousand.

Senator BENNETT. How many?

Dr. DEARING. A few thousand. I would say—

Senator BENNETT. A smaller town than the number of enrollees in the plan?

Dr. DEARING. I think possibly.

Senator CURTIS. How many doctors are involved?

Dr. DEARING. There are five or six doctors who provide the basic services. They use outside services for specialties from Duluth and things of that sort; but the core is there.

Senator CURTIS. How far is Duluth?

Dr. DEARING. Forty miles, perhaps.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. Well, thank you very much for your presentation. We appreciate it.

Dr. DEARING. Thank you, Senator.

(Statement by the Group Health Association of America presented by Mr. Cohelan and Dr. Dearing follows:)

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA, PRESENTED BY
JEFFERY COHELAN, EXECUTIVE DIRECTOR, AND W. PALMER DEARING, M.D., MEDICAL CONSULTANT

INTRODUCTION

Mr. Chairman, my name is Jeffrey Cohelan. I am the Executive Director of Group Health Association of America. GHAA is the national association representing the major community and consumer oriented prepaid group practice plans in the United States and Canada. Our affiliated plans are responsible for the health care of four million people and, in addition, GHAA is the recipient of a federal grant for the purpose of organizing prepaid group practice plans in some thirty-three cities over the next few years. Currently we are active in some twenty cities where our type of Health Maintenance Organization is in various stages of development.

I am accompanied this morning by W. Palmer Dearing, M.D., Medical Consultant to GHAA and my immediate predecessor. Dr. Dearing served as Executive Director for ten years and before that was the Deputy Surgeon General of the United States Public Health Service. He is particularly qualified to speak on the subject of our interest in this legislation.

Mr. Chairman, you may recall that GHAA appeared before this Committee on April 25, 1971, during the hearings on various national health insurance proposals. At that time we addressed ourselves in a general fashion to the Health Maintenance Organizations concept in the context of our experience and expertise with regard to prepaid group practice plans. We discussed the benefits which a well-structured Health Maintenance Organization could offer as an alternative form of health care delivery and set forth some of the difficulties and expense involved in its creation. We recommend specific guidelines for those who seek to organize and those who seek to regulate Health Maintenance Organizations. We will not take the time of the Committee this morning to reiterate that testimony. We will confine ourselves to the existing Health Maintenance Organizations provisions of H.R. 1. We also have some comments on catastrophic health insurance and the peer review amendments in the event the Committee considers adding these to the bill.

The Health Maintenance Organizations provisions of H.R. 1 will be the first major legislative input into the Health Maintenance Organizations concept and will have an important impact on the national health policy. Thus in its work on the Health Maintenance Organizations provisions of H.R. 1, this Committee has an important opportunity to improve the chances for financially sound and well-structured Health Maintenance Organizations. Ultimately, we hope that providing Medicare benefits through prepayment to Health Maintenance Organizations will result in Medicare beneficiaries constituting a substantial membership base in Health Maintenance Organizations.

But we do not expect any appreciable immediate increase in Health Maintenance Organizations membership until some time has elapsed after the enactment and implementation of these provisions. Rather, we think there will be a slow but steady growth of Medicare beneficiaries in Health Maintenance Organizations, which will somewhat parallel the growth and acceptability of Health Maintenance Organizations by the public as a whole. Medicare beneficiaries will be reluctant to change traditional patterns of health care simply because an alternative system has been made available to them. The small number of Health Maintenance Organizations now existing in the country and available for immediate enrollment will not of themselves bring about rapid growth.

Gradual development of Medicare involvement with Health Maintenance Organizations has advantages. Unlike Medicare, where an entire system was created overnight and promptly covered millions, a slower rate of Health Maintenance Organization participation will afford time for re-examination, analysis, and modification.

However, we have some problems with the present provisions of H.R. 1 as they now exist. Under the present bill, the per capita payments to Health Maintenance Organizations are limited to a maximum of 95% of the cost of the

covered services if they were furnished by other than a Health Maintenance Organization. We have no doubt that a well managed Health Maintenance Organization will have little difficulty providing the services within these limitations. However, we feel that the Committee should re-examine this provision and set the limitation at 100% of the cost of the services in the non-Health Maintenance Organization area.

The Health Maintenance Organizations concept has been designed to provide an alternative health care system. Through competition with existing systems it is hoped that Health Maintenance Organizations will lead to higher quality, more efficient health care with maximum economic utilization of the health care dollar.

The real concern then, is medical care. The real test is who offers the most attractive package of medical benefits. Under H.R. 1 a Health Maintenance Organization can improve the medical package by using the difference between the actual cost of care and the maximum limitation for additional benefits for Medicare beneficiaries. The natural result of injecting competition in health care delivery systems is to direct all systems of health systems toward improvement in quality, efficiency, and economy. It would seem only fair to put the competing systems on an equal footing.

We also urge the Committee to amend the definition of Health Maintenance Organizations to require a minimum number of full-time physicians. Since 1963 GHAA has felt as a matter of policy a pre-paid group practice plan must have a minimum of four full-time physicians in four basic specialties—OB-GYN, internist or family practitioner, pediatrician and surgeon. Regulations under the Group Practice Facilities Act of 1966 and the 1970 Health Cancer and Stroke Act Amendments provide for this in the definition of prepaid group practice. We know that a physician who spends part of his time in a prepaid group practice and part of his time as a solo practitioner, has dual economic incentives, which might act adversely to the prepaid group practice. This rule is just as applicable to the Health Maintenance Organization.

CATASTROPHIC INSURANCE

I would like now to comment on one proposal to help solve the nation's health care crisis which has attracted considerable support among some segments of the health industry and the public which would seriously affect prepaid group practice plans. This is the proposal to initiate a Federally sponsored program of major medical or catastrophic illness as the next step toward meeting the nation's recognized health needs.

Group Health Association of America recognizes the problem of the tragic cases of families bankrupted by serious, expensive long-term illnesses. Our Association would not oppose any effective measure for dealing with this problem.

We urge this Committee to recognize, however, that catastrophic coverage is no substitute for comprehensive health coverage. Moreover, emphasis on catastrophic coverage right now would almost certainly undermine long overdue efforts now underway to give proper emphasis to primary care and ambulatory services. Now emphasis on major illness would most certainly distort the allocation of national health care resources—turning them again toward hospitalization and other institutional treatment and away from prevention, home care and other neglected aspects of health care.

All the catastrophic coverage proposals share the fundamental idea that insurance should take over only after a family has paid out hundreds or even thousands of dollars for medical expenses.

Experts in health care economics who do not come from the vested interests in the field tell us that national insurance limited to catastrophic coverage would accelerate the current inflation of health care costs. Also, we have had sufficient experience in the years of Medicare to realize that providers will be motivated to raise their prices so that a family or individual can become eligible for catastrophic benefits. The net result would certainly be a further boost in charges for all aspects of health.

Other testimony before this Committee—notably that of the AFL-CIO and the National Council of Senior Citizens—has gone much more into detail with respect to the disastrous push toward further inflation and the distortion of priorities in deployment and use of our health resources, that would result from a separate catastrophic illness insurance program.

If, however, catastrophic illness or major medical insurance were to be enacted as a specific benefit in whatever context, special provisions must be made for group practice plans if they and their subscribers are not to be seriously disadvantaged and over-charged. The comprehensive benefits of group practice plans include de facto major medical benefits in their regular contracts. Whereas major medical coverage added upon typical commercial and Blue Cross/Blue Shield contracts would cost \$4.00 to \$4.50 per month, the supplemental coverage added to a group practice plan benefit would cost in the neighborhood of \$1.00 to \$1.50 per month. A single national premium charging indemnity insurance rates would take about \$3.00 per month from the group practice plan subscribers.

Therefore, a catastrophic program based on cost reimbursement or premium subsidy after large deductibles makes the value of the catastrophic override worth much less to members of a prepaid group practice than to other health plans. Further, prepaid group practice plans are built upon incentives for minimal hospitalization and preventive health care. It would seriously diminish the effectiveness of prepaid group practice plans in the health care market if these differences were ignored.

In order to assure the members of our plans equitable treatment if a catastrophic health insurance program along the lines of S. 1376 is enacted, there should be provision for prepayment to group practice plans on behalf of their members from the program. The prepayment should equitably relate to payments from the program in the non-prepaid group practice area. This prepaid premium from the Federal program should take into account the cost of care in the geographic area where the plans operate. Furthermore, the prepaid premium should be integrated into the regular pay-structure of our plans. Such a prepaid premium under a catastrophic health insurance program will help to preserve the equitable position of our members to that of members of other plans.

Prepaid group practices should not be required to cover all of the services involved to the extent of the deductible under the catastrophic program. This could cause diversion of the plan resources from higher priority services, or might mean a further burden in the form of rate increases on our members. This is especially true in the case of smaller plans where even a single case has a great actuarial impact.

At this point, Mr. Chairman, I submit for the record some suggested language amending S. 1376 to accomplish the foregoing.

"Section 2004(a)(4). In the case of an organization which provides or arranges comprehensive health care services for a defined population, the Secretary shall authorize per capita payments to such an organization on behalf of eligible individuals enrolled in such organizations. A combined per capita payment may be made to such organizations for the services set forth in subsections 2004(a)(2) and 2004(a)(3), which are provided or arranged by such organizations. Such per capita payments shall equal the average payments made on behalf of eligible individuals residing in the general geographic area served by such an organization and shall be based upon the undertaking by such organizations to provide or arrange services to eligible individuals enrolled in such organizations and shall not be based upon specific services rendered to each eligible individual.

PROFESSIONAL STANDARDS REVIEW

Finally, Mr. Chairman, we have some comments on the amendment introduced by Senator Bennett on January 25, 1972, dealing with Professional Standards Review Organizations.

Our main concern with the peer review proposal from its potential for review of prepaid group practice operations and procedures by physicians whose orientation has in the main been outside a prepaid group practice setting. We were less concerned about the historical antagonism of the professional societies to our system of health delivery than we were about the lack of complete understanding of most physicians of the complexities of our system.

Prepaid group practices have always had intrinsic peer review objectively rendered. It is the objectivity of peer review that has always been our concern. We felt it may be difficult to establish by statute a system of peer review which would be free from bias and rendered with a full understanding of our operation.

We have some concern with the authorization and indeed encouragement for PSROs to go into the insurance business through risk sharing as provided in Section 1170 of Senator Bennett's amendment. This would seem to make possible

a whole chain of insuring organizations which were also carrying out PSRO functions, but without any of the standards and controls so elaborately provided for with respect to Health Maintenance Organizations. Whether or not PSROs can also appropriately undertake risk for the services they are supposed to monitor also seems questionable.

Mr. Chairman, this concludes our statement and we would be happy to respond to any questions you may have.

Senator ANDERSON. Dr. Gibson?

**STATEMENT OF ROBERT W. GIBSON, M.D., MEDICAL DIRECTOR,
THE SHEPPARD AND ENOCH PRATT HOSPITAL, TOWSON, MD.**

Dr. GIBSON. Mr. Chairman and members of the committee, my name is Dr. Robert W. Gibson. I am medical director of the Sheppard and Enoch Pratt Hospital. I am a trustee of the American Psychiatric Association and the past president of the National Association of Private Psychiatric Hospitals.

I am honored to have this opportunity to speak to you on behalf of the American Psychiatric Association, whose 19,000 members have the primary responsibility for the medical treatment of the mentally ill in our country, and to express the views of the National Association of Private Psychiatric Hospitals, whose 150-member hospitals have the primary responsibility for the private hospital care of the mentally ill.

It has been my privilege to present testimony before this committee in 1965, 1967, and again in 1970. Today I will speak about some issues that have been discussed in previous testimony and will address some new areas of concern. In the interest of time, my remarks will be quite brief on those items covered in previous testimony. Appended to this testimony I present is a relevant and more detailed statement from previous testimony that I respectfully request be made a part of the record.

Senator ANDERSON. It will be made a part of the record.

Dr. GIBSON. Thank you.

In 1965 I asked that mental health benefits be included under medicare and medicaid. Members of the Senate Finance Committee played a major role in achieving what the psychiatric profession hailed as a major breakthrough by providing broad benefits for the treatment of the mental ill under both the medicare and medicaid programs, albeit with some significant limitations.

In 1967 I discussed those provisions that imposed discriminatory limitations on treatment of the mentally ill. Specifically, I asked that under title XIX medical assistance for eligible individuals under the age of 65—families with dependent children, blind, disabled, and indigent—be made available in psychiatric hospitals and community mental health centers rather than being limited only to the general hospital.

Under title XVIII, I asked—I asked at that time that the higher coinsurance and top limits applied to outpatient psychiatric treatment be removed in order that outpatient care of the mentally ill could be at the same level as all other medical conditions. These limits were such as to very much hamstring any kind of outpatient care of the mentally ill; and I asked further for the removal of the 190-day lifetime limit imposed only on treatment in a psychiatric hospital.

The Senate Finance Committee was understandably concerned about the potential fiscal impact of these recommendations and therefore requested the Secretary of Health, Education, and Welfare to study existing programs of the law, evaluate the problems involved in expanding or extending coverage for the mentally ill and to make recommendations for change.

In 1970, I again expressed the concern of psychiatrists with regard to the various limitations applied only to the mentally ill. In addition, I indicated our concern about the proposed decreases in the Federal medical assistance percentage—FMAP—by one-third after 90 days of care in a mental hospital and the limit on the FMAP for 365 days of care in a mental hospital and in an individual's lifetime. At that time, unfortunately, the study requested by the Senate Finance Committee for evaluation of the problems involved in expanding coverage to the mentally ill was not available.

Today my request is again basically for the elimination of all the discriminatory limitations applied to the treatment of the mentally ill: removal of the 190-day limit under medicare on inpatient treatment and removal of the higher coinsurance for outpatient care and services; under medicaid the removal of restrictions that limit treatment of eligible individuals under 65 to general hospitals. This is extremely important. This way the mentally ill could receive active rehabilitative treatment in all accredited facilities including State mental hospitals, private psychiatric hospitals, community mental health centers and the general hospitals. Again, under medicaid, I recommend the elimination of the provisions that would lower the Federal medical assistance percentage—FMAP—for care in mental hospitals.

Today I can now assert with confidence that these changes would not create serious fiscal problems. The study requested by the Senate Finance Committee—Research Report No. 37, by HEW, SSA, Office of Research and Statistics, published in 1971, "Financing Mental Health Care Under Medicare and Medicaid"—provides a detailed analysis of utilization and costs of psychiatric benefits under medicare and medicaid. I will not dwell on these findings since this report has been studied by this committee.

I do want to note, however, that in the fiscal year 1969 medicare and medicaid expenditures for psychiatric services on behalf of patients aged 65 and over represented only about 3.7 percent of the total medicare and medicaid outlay. It is of particular interest that the data show that utilization of and charges for outpatient services under medicare in 1967 were very low—less than 1 percent of all supplemental medical insurance enrollees ever used the services—and total charges were only \$2.6 million.

Since the expenditures for psychiatric service represent a tiny percentage of the total outlay for all services, it is evident that broadening the scope of benefits to make them equivalent to care for other medical conditions would not impose a serious burden on the program. We strongly support those provisions that would include under medicare the disabled, including those disabled by mental illness; and, if provisions are added for benefits to protect against catastrophic illness, we would urge that these not perpetuate those restrictions under medicare that are discriminatory against the mentally ill. Mental illness is

one of the worst catastrophes that can befall a human being and adequate protection should be provided against it. We are also appreciative of the efforts being made to alleviate the damaging effects of social conditions which perpetuate poverty since the poor and disadvantaged all suffer a high incidence of mental illness.

I refer here particularly to the family program.

Further corroboration that the cost of psychiatric care can be covered comes from a study entitled "Insurance Plans and Psychiatric Care: Utilization and Costs" now being completed by the American Psychiatric Association under a grant from the National Institute of Mental Health. The findings of this study by a panel of experts headed by a leading health economist, Dr. Louis Reed, will be published in the near future, and I will make a point of providing copies to the members of this committee.

Specifically, this study shows that under a wide variety of health insurance plans, the charges for hospital inpatient care for mental conditions are in the range of from 3 to 6 percent of charges for inpatient hospital care for all conditions.

Under many plans which offer full coverage of ambulatory psychiatric care, the number of physician office visits for mental conditions was from 2 to 4 percent of the total. Even under the high option of the Blue Cross-Blue Shield plan for Federal employees which covers ambulatory psychiatric care on the same basis as ambulatory care for other conditions—80 percent of charges after \$100 deductible—benefit payments for such care amounted in 1969 to an annual approximate figure of just \$2.15 per person covered; and under this program which provides virtually the same coverage for mental conditions as for all conditions, total benefits paid for all types of care for mental conditions including both inpatient and outpatient, amounted annually to only \$7.07 per person covered.

I cite this study particularly because this is an outstanding limit. This is the highest kind of costs that are encountered.

The American Psychiatric Association study on utilization and costs for treatment of mental illness shows that the cost of coverage for psychiatric care under insurance programs is relatively small. I submit that both these studies demonstrate that it is economically feasible for the Federal Government to provide a full range of active rehabilitative psychiatric care for the mentally ill indigent and disadvantaged under the medicare and medicaid programs; and, further, that there need be no arbitrary restrictions on where the patient can obtain this care; rather, it should be made available to the mentally ill indigent and disadvantaged in all accredited facilities including State mental health programs, the private psychiatric hospital, the community mental health center, by private psychiatrists, in the general hospital and in the health maintenance organization.

I am aware that many of these points were presented to this committee some 2 weeks ago in testimony on behalf of the State mental health program directors. I would like to emphasize that we support their recommendations for the increase in support for the mentally ill indigent. We were particularly appreciative of Senator Long's comments that clarified that it was intended in section 254 of H.R. 1 that public hospitals for mental diseases might be certified, at least in

distinct parts, as intermediate care facilities for the aged mentally ill.

I would now like to address my remarks to those provisions of H.R. 1 related to HMO's, since section 207 would create incentives for States to contract with HMO's or similar organizations by providing for an increase of 25 percent, up to a maximum of 95 percent, in the Federal medical assistance percentage to States having contracts with HMO's or other comprehensive health care facilities.

Members of the American Psychiatric Association are supportive of the concept of the HMO in terms of its emphasis on preventive health care and maintenance and because it shows promise under appropriate circumstances of being an efficient delivery system. Psychiatrists are concerned, however, that many prepaid group plans, prototypes of the HMO, have provided little coverage for psychiatric conditions. We urge that the legislation language concerning HMO's provide guarantees that the mentally ill, particularly the mentally ill indigent and disadvantaged, have an opportunity to obtain their treatment within HMO's. To this end we urge that the definition of an HMO specify that it must provide those health services which a defined population might reasonably require to be maintained in good mental health as well as good physical health.

We believe that expenditures under Federal programs should be used to support active rehabilitative care and that they should be utilized, not just to maintain the status quo but to improve State mental health programs, community mental health programs and those services provided by the private sector.

To this end we strongly support the establishment of and further experimentation in the use of utilization review, medical audit and peer review to assure the continued improvement of services, the maintenance of quality of services and to provide guarantees to the Congress that funds are used for the purposes intended. You can rely on the members of the American Psychiatric Association to work toward these goals. Thank you.

Senator ANDERSON. Any questions.

Senator CURTIS. How many or what portion of the company, as distinguished from various units of government, company health plans, include full psychiatric services?

Dr. GIBSON. By company you are referring to a prepaid group practice type of plan?

Senator CURTIS. Well, regardless of how they handle it, a company that is the employer of people often has through private insurance or some other a health and hospital plan for their employees.

Dr. GIBSON. Yes, sir.

Senator CURTIS. My question is, do most of them include full psychiatric services?

Dr. GIBSON. Most of the plans of that type do include some psychiatric services. They almost all have some limitations that are somewhat different than they have for other illnesses. For example, if the particular plan involves an 80 percent coinsurance feature, they may make it a 50-percent coinsurance feature for the psychiatric condition. They often are somewhat more limited on the number of outpatient visits; but as a general answer, most do provide some psychiatric coverage but very few provide it on the same basis as other conditions.

Senator CURTIS. What is the situation in reference to Government employees?

Dr. GIBSON. The Government employees' insurance program is one of the very strongest plans in terms of psychiatric coverage. There are virtually no special limits imposed on psychiatric care. I can say—

Senator CURTIS. It is treated like other illness?

Dr. GIBSON. Yes; it is treated just like another illness and I can say as a generalization that psychiatrists are most appreciative and most strongly endorse the leadership that has been taken because clearly the Federal Government was instrumental in asking for this kind of coverage and it is a kind of leadership that has been taken to place the treatment of the mentally ill on the basis of other individuals which we very firmly believe in.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. Thank you very much.

Dr. GIBSON. Thank you.

(The appendix to Dr. Gibson's statement follows:)

Mr. Chairman and members of the committee, I am honored to have this opportunity to speak to you on behalf of the American Psychiatric Association, whose 18,000 members have the primary responsibility for the medical treatment of the mentally ill in our country, and to speak on behalf of the National Association of Private Psychiatric Hospitals, whose 134 member hospitals have the primary responsibility for the private hospital care of the mentally ill.

As psychiatrists, we are indebted to the members of this Committee for their continuing interest in those provisions of the Social Security Legislation affecting psychiatric care. And, we are particularly grateful to your Chairman, Senator Long, for his personal efforts. The mentally ill are neither articulate nor effective spokesmen in their own behalf and it is indeed fortunate that in Senator Long they have a dedicated champion, sensitive and concerned about their needs.

Gentlemen, I speak to you today with grave concern and disappointment about the legislation before us. It does nothing to eliminate the discriminatory provisions of Medicare and Medicaid. In fact, Section 225 singles out the mentally ill for even further limitations under the Medicaid program by a decrease in Federal matching of one-third after 90 days of care in mental hospitals and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime.

In testimony presented before this Committee some three years ago, I asked for the elimination under Title XVIII of the special financial limitations placed on psychiatric outpatient treatment.

I asked for the elimination under Title XVIII of the 190 lifetime limit placed on treatment in a psychiatric hospital.

Three years ago the reluctance to act on these recommendations because of the deep-seated concern about the overall costs of the Medicare and Medicaid programs was understandable. The apprehension about the *total costs of the programs* was shared even though I did not believe that our recommendations regarding psychiatric benefits would create fiscal problems.

But now, three years later, there is evidence that the concern about costs of psychiatric care is not warranted. In 1968, based on claims paid under Medicare, payments for psychiatric hospitalization represented only 0.7% of the total amount reimbursed and the suggested changes would add little if anything to this.

I will review only briefly the recommendations concerning outpatient treatment under Title XVIII. Under the supplementary medical insurance benefits for the aged, outpatient treatment may be paid for after a \$50 deductible, with the patient paying 20% and with no top limit, *but in the case of psychiatric treatment*, the patient must pay 50% after the deductible, and there is a top limit of \$250. This limitation seriously curtails outpatient treatment for the aged patient. In many instances the limitation will prevent the adequate outpatient evaluation and screening that have been shown to decrease unnecessary hospitalizations. The retention of this limitation on psychiatric outpatient services is particularly incongruous in the light of comments on page 38 of the Report of the Committee on Ways and Means on H.R. 17550 noting a wish "to encourage

states to make more efficient use of health services" and a wish to "create incentives to encourage outpatient services and disincentives for long stays in institutional settings."

Thus, I ask for the elimination of discriminatory provisions limiting outpatient psychiatric care for the treatment of the aged under Title XVIII.

This would mean deleting the phrase "(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is smaller: (1) \$312.50 or (2) 62½% of such expenses." P.L. 89-97, Title XVIII, Section 1833(c).

Again addressing myself briefly to Title XVIII, there is a 190 day lifetime limit placed on treatment in a psychiatric hospital. No such limit is placed on treatment in a general hospital, even if such treatment in the general hospital is for a psychiatric illness. It makes no sense to force a patient to shift from one institution to another and that is exactly what can happen. Only infinitesimal financial savings could be achieved through this limitation and in fact it is possible that by forcing patients into more expensive general hospital beds this 190 day lifetime limitation is increasing the costs to the program.

Therefore, I ask you to eliminate the 190 lifetime limit on treatment in a psychiatric hospital under Title XVIII.

This would mean deleting the phrase "(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime." P.L. 89-97, Title XVIII, Section 1812(b).

In its Annual Report on Medicare, the Health Insurance Benefits Advisory Council recommended the enactment of legislation which would allow the participation of community mental health centers in the Medicare program. Mental health centers that are affiliated with general hospitals are certified under Medicare as part of the general hospital; centers that are affiliated with a psychiatric hospital are certified as part of that hospital. But, a number of new centers have developed independently and are free standing. To qualify as a Medicare provider for service and receive reimbursement for inpatient care, present law requires that the free standing mental health centers meet the conditions of participation for psychiatric hospitals.

We urge the enactment of legislation that would allow the participation under Medicare of all qualified community mental health centers. This is consistent with the development of such centers throughout the country to provide more comprehensive treatment services, accessible to the population groups served.

To accomplish this, the inpatient services in these centers could be covered under Part A of the program, subject to the same conditions and limitations as are applicable to inpatient psychiatric benefits. Payment for outpatient services could be made under Part B, on a reimbursable cost basis in much the same manner as outpatient hospital services.

Turning now to Title XIX, medical assistance is provided for persons under 65 who are in families with dependent children, are blind, or permanently and totally disabled, and whose incomes and resources are insufficient to meet the costs of necessary medical services. Recipients under the age of 65 may receive inpatient psychiatric treatment on the psychiatric unit of a general hospital, but *not* in a mental institution, whether it be a public or a private mental hospital, or even a community mental health center.

This limitation is highly objectionable. Not a single state in our country has a sufficient number of psychiatric units in general hospitals to treat the persons now eligible for benefits under Title XIX. Furthermore, the psychiatric unit of a general hospital provides only a limited spectrum of care—primarily diagnostic and brief stay. They seldom have the full range of specialized mental health professionals, and the shortage of facilities and staff to treat children is particularly severe. Treatment in a public mental hospital, a private psychiatric hospital, and a community mental health center was included by the Congress under Title XVIII and the failure to do so under Title XIX is fundamentally inconsistent with the emphasis on community psychiatry so vigorously supported by the Congress.

To do this, you must include all the properly qualified institutions. We want the definition of a hospital to include the public mental hospital, the private psychiatric hospital, and the community mental health center.

This would mean deleting the phrase "other than services in an institution for . . . mental diseases." P.L. 89-97 Title XIX, Section 1905 (a) (1).

I would now like to refer to Section 225, of HR 17550, which increases by 25% the Federal medical assistance available for outpatient hospital service and clinic service, but also provides:

"after an individual has received inpatient services in a hospital for mental diseases on 90 days occurring after December 31, 1970 (whether or not such days are consecutive) the Federal medical assistance percentage with respect to any such services furnished to such individual on an additional two hundred and seventy-five days (whether or not such days are consecutive) shall be decreased by 33½ per centum thereof and no payment may be made under this Title for any such services furnished to such individual on any day after such 275 days."

As indicated in the Report of the Committee on Ways and Means of HR 17550:

"The proposal to increase the Federal matching for outpatient, clinic and home health services is directed at encouraging the States to provide early diagnosis and treatment of illness, preventive services, and alternatives to institutional care intended to reduce the need for and use of inpatient services.

"The proposed limitations on length of stay in mental institutions reflect the assumption that medical treatment of mental illness inpatients generally does not exceed three months and for patients over 65 rarely continues beyond a year."

Outpatient services should be encouraged not only because they are more economical but because when used appropriately they are in the best interests of the patient. The assumption that treatment of psychiatric inpatients does not exceed three months is a generalization and over-simplification. In previous testimony I have indicated that many elderly patients do respond to an active treatment program in less than 90 days, but there also are significant numbers that need care over a prolonged period. Arbitrary and inflexible limitations such as those proposed will unquestionably deprive many patients of needed treatment.

It must be noted that a high percentage of elderly patients in mental hospitals are suffering from significant degrees of physical impairment and do receive needed medical treatment. Limiting the Federal medical assistance available to hospitals for mental diseases would encourage shifting such patients to more expensive medical and surgical institutions where, incidentally, the psychiatric needs would not be adequately met.

Admittedly some States have not effectively utilized the Medicaid funds available for psychiatric services. Nevertheless, these programs do have meaningful potential and it would be a disservice to disqualify all in one sweeping judgment. In attempting to eliminate those programs that are not delivering effective services, it would be preferable to insist on more adequate documentation of services rendered and to intensify utilization review.

A further limitation in Section 225 affects skilled nursing homes:

"(B) after an individual has received care as an inpatient in a skilled nursing home on 90 days (whether or not such days are consecutive) during any calendar year, the Federal medical assistance percentage with respect to any such care furnished thereafter to such individual in the same calendar year shall be decreased by 33½ per centum thereof;"

This limitation will only intensify the plight of the elderly person suffering from mental illness because many such patients with lesser degrees of mental impairment are being cared for effectively in the skilled nursing homes. This further withdrawal of support for older persons with psychiatric disabilities would be most unfortunate.

In brief, I strongly favor the increased Federal medical assistance being made available for outpatient hospital service but oppose those reductions and lifetime limitations on the assistance available for inpatient services in a hospital for mental disease and the curtailment of assistance for skilled nursing home care.

Our associations ask for an insurance benefit system that would enable the profession of psychiatry to provide the full range of psychiatric treatment to all persons deemed eligible and to do so on an effective basis. We look forward to the opportunity to work collaboratively with the Federal Government in achieving this. We pledge our wholehearted support to the Congress and to

the public and private agencies in making such an equitable system fully workable and maximally effective.

ROBERT W. GIBSON, M.D.,
Medical Director, the Sheppard and Enoch Pratt Hospital.

Senator ANDERSON. Dr. Catchings?

STATEMENT OF JAMES A. A. CATCHINGS, D.D.S., MEMBER, COUNCIL ON DENTAL HEALTH, AMERICAN DENTAL ASSOCIATION; PAST PRESIDENT, NATIONAL DENTAL ASSOCIATION; ACCOMPANIED BY HAL M. CHRISTENSEN, DIRECTOR, WASHINGTON OFFICE, AMERICAN DENTAL ASSOCIATION

Dr. CATCHINGS. Mr. Chairman and members of the committee, my name is Dr. James A. A. Catchings, of Detroit, Mich.

In addition to maintaining a private dental practice, I am a member of the Council on Dental Health of the American Dental Association and a past president of the National Dental Association. I am here today on behalf of those two organizations. With me is Hal M. Christensen, director of the American Dental Association. We appreciate this opportunity to present our views on some of the complex health issues affected by provisions of H.R. 1. Our oral testimony is brief, Mr. Chairman. We have, however, two appendixes attached to it and would be grateful if they could also be made a part of the record.

Senator ANDERSON. They will be made a part of the record.

Dr. CATCHINGS. Hospital admissions for dental services under medicare: H.R. 1, as passed by the House, has in section 256 of part C of title II a technical amendment that would remedy a source of confusion that exists under part A of medicare as presently written.

Briefly, the provision would permit a dentist to certify to the necessity for hospital admission of a medicare beneficiary for treatment of a dental condition. Upon such certification and admission the patient's hospital expenses would be covered on the same basis as any other medical admission. There would be, of course, no coverage of the dental services themselves.

Enactment of the provision would eliminate an existing cumbersome and unnecessary procedure and bring medicare into conformity in this regard with typical health benefit programs in the private sector, including those offered to employees of the Federal Government. We urge you to retain this provision of H.R. 1.

Equity in outpatient benefits coverage: Along this same line there is need for a further clarifying amendment related to the definition of a physician under section 1861(r) of title XVIII. Although the original intent behind this section was to make clear that a dentist would be authorized to provide any covered service that legally is within the scope of his license to practice, the administrators of the program have narrowly construed the language to include only covered services that require surgical intervention. Thus, the expenses of a patient with a condition such as an infection that can be treated medically may not be reimbursed if the treatment is rendered by a dentist, usually one who specializes in oral surgery, but would be reimbursed if the same treatment were rendered by a physician. The

association requests that this inequity be remedied by adoption of the following amendment to H.R. 1:

Section 1861(r) of the Social Security Act is amended by striking subparagraph (2) in its entirety and inserting in lieu thereof the following:

(2) A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the state in which he performs such function but only with respect to (A) surgery or other treatment related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone.

Professional standards review organization: In late January, Senator Bennett introduced amendment 823 to H.R. 1. This amendment would establish a new title XI creating a professional standard review procedure for services "for which payment may be made under the Social Security Act."

It is apparent and understandable that the framers and supporters of the amendment are anxious that the core structure of the PSRO not be fragmented but that instead the central responsibility for its operations be clearly assigned to one organization, with the local medical society being the preferential choice.

Senator BENNETT. May I interrupt you at that point?

Dr. CATCHINGS. Yes, sir.

Senator BENNETT. That last statement is wrong. We have leaned over backward to keep the local medical society from controlling the PSRO and that is why we have insisted that it must be a separate organization, that every doctor must be given access to it whether or not he is a member of the medical society and, to the extent that the leadership of the medical society encourages its members to participate, we welcome that.

But we have—I have been very careful from the beginning to make it clear that this is an organization that is entirely outside the privately organized medical societies.

Dr. CATCHINGS. Thank you very much, Senator.

We raise no basic objection to that framework. It is nonetheless true that large numbers of dentists and other nonphysician health professionals render services under social security programs to many thousands of beneficiaries. We have no doubt that physicians themselves would be the first to concede that their training does not qualify them to determine the necessity for or quality of dental care. If the PSRO is truly going to work with respect to dental services, then it is essential to require that dental societies be delegated the responsibility for the review of such services.

We have attached to our statement, as appendix I, suggestions for changes in line with our recommendation. We urge the committee's favorable consideration of them. Also included as appendix II are recent official policy statements of the American Dental Association, in which the National Dental Association concurs, underlining our commitment to a broad-based peer review system, containing sanctions for governmentally financed health-care programs.

Medicaid: Beginning some 30 years ago, organized dentistry began urging the Federal Government to take a more active role in bringing dental care to the needy and near needy, especially the children in those categories. Candidly, our representations met with little suc-

cess over the years. As short a time ago as calendar year 1966, total public sector spending for dental care—Federal, State, and local—was \$57 million; today it is about \$260 million. Medicaid's enactment marked the first time that some emphasis was put on dental care for the needy and near needy by the public sector.

The committee may recall that at the time of Medicaid's enactment, Senator Ribicoff led a drive to include dental services for children as a mandatory benefit under the program. The committee approved the amendment and its approval was then confirmed by the full Senate. Regretfully, the Ribicoff amendment was deleted in conference. The emphasis on dental care, then, has been optional rather than obligatory; nonetheless, it generated a real beginning for the first time in history.

This, we think, is one of the bright spots in Medicaid history. We fully recognize that there are many other chapters that are not so agreeable. There seems to be evident intention to make changes in Medicaid, perhaps even beyond what is already in H.R. 1.

Our association's most urgent concern is that the foothold established by Medicaid with respect to dental care not be lost. Indeed, that foothold should be enlarged as swiftly as is prudent until comprehensive dental care is reasonably available to every American irrespective of income.

The committee action on the Ribicoff amendment of 1965 was evidence that it, too, feels this commitment. In the years since then, it is true the entire Nation has had to face some sobering realities about the difficulties that lie between concept and implementation of health care. But nothing that has happened can justify a total Federal abandonment of its role in bringing dental care to the poor.

Our professional preference still is to concentrate first on children. That is also, we believe, the most promising path from a fiscal point of view. It may be that it is not feasible to include all children at once. Perhaps we must proceed more modestly on an incremental basis. But whatever ultimate course of action the committee takes with respect to Medicaid, we hope that it will provide adequately for dental care of the poor, with emphasis on children.

Insurance against catastrophic illness: In his statement at the opening day of these hearings, the chairman said he hoped "that the committee will receive testimony regarding * * * insurance protection against the costs of catastrophic illness."

A common factor in any proposal of this nature is the concept of a deductible for personal health expenses, a deductible that, once satisfied, allow Federal assistance to start.

Some of the bills now pending would not permit a family to include its dental care expenses in the computation leading toward satisfaction of the deductible. Where this has occurred, as in S. 1376, we believe it to have been inadvertent.

Regular dental care is surely an intrinsic part of a family's total health care. Public policy has long recognized it as such, as is shown, for example, by its being part of the medical care deductions allowed in Federal and State income tax returns. The preventive aspects of care are more clear cut with respect to dental disease than with most other kinds of illness since, despite its universal occurrence, most dental disease is readily preventable.

Dental care services account for about 9 percent of the private health dollar. An average family obtaining reasonably regular dental care might spend some \$160 annually. To the family, that is clearly a significant expenditure. Its addition to the deductible category, however, would not add unduly to the cost of the program. In any given year, of course, some families may well face larger expenditures for dental treatment that cannot be postponed. Treatment for advanced periodontitis, for example, can extend for many months and cost as much as \$700 to \$1,000. Inclusion of such essential health expenditures in the deductible category seems to us to be proper and necessary.

While most dental disease is admittedly not catastrophic as that term is defined in this context, some manifestations can indeed have a catastrophic effect on a family's finances. The two most obvious examples of this are oral cancer and cleft lip and/or palate. We urge that consideration be given them in defining what constitutes disease of a catastrophic nature.

Mr. Chairman, this concludes our testimony. On behalf of the National Dental Association and the American Dental Association, I want to express our pleasure at having this opportunity to appear.

Mr. Christensen and I would be glad now to respond to any questions.

Senator ANDERSON. Are there any questions?

Senator BENNETT. Mr. Chairman, I would like to express my thanks to Dr. Catchings for his support of the principle of peer review and to assure him that the language of the bill as it is finally adopted, if any peer review is adopted, will make sure that only dentists review the work of dentists as only doctors should review the work of doctors.

Now, we may not agree as to who is going to select those reviewers. It seems to me that having taken a strong stand on the principle that organized medicine should not be the agency to select the doctors who should participate in peer review, I have to take the same stand with respect to organized dentistry, and I think in the end that is an important phase of the success of the program.

Dr. CATCHINGS. Very important, Mr. Senator, and we certainly thank you for your words on that.

Senator CURTIS. Mr. Chairman, I just want to refresh my memory about these programs. Dental services per se are not included in medicare, are they?

Dr. CATCHINGS. No; not per se.

Senator CURTIS. But I believe you said if a medicare patient would have an infection and went to the hospital, and the infection was handled by a medical doctor it would come under medicare?

Dr. CATCHINGS. Yes.

Senator CURTIS. Even though it was related to a tooth?

* Dr. CATCHINGS. Maybe I would let Mr. Christensen answer it.

Mr. CHRISTENSEN. That is not 100-percent correct.

Senator CURTIS. Correct me on that so I get it straight.

Mr. CHRISTENSEN. What is covered under medicare are those conditions that may be treated either by a physician or a dentist. That was the intent of the amendment that is in there now. All routine type dental care is excluded specifically.

Senator CURTIS. What is the situation in reference to medicaid?

Mr. CHRISTENSEN. Medicaid is an optional program with the States. Some of them—New York, Massachusetts, Illinois—have fairly comprehensive programs. Others have little more than emergency care and some not even that.

Senator CURTIS. So, insofar as the Federal law is concerned dental services are in medicaid because the States could go ahead——

Mr. CHRISTENSEN. That's right; they could do it and the Federal Government in that case matches at a regular basis.

Senator CURTIS. And there the test is a matter of income?

Mr. CHRISTENSEN. Right.

Senator CURTIS. I understand your recommendations about peer review and I understand about the definition of doctors; I don't know as I have used the right term, but are you at this time advocating the expansion of any programs to include dental care?

Mr. CHRISTENSEN. Only with respect to programs such as medicaid which are for the needy. We believe that those programs should include a reasonable provision for dental care.

Senator CURTIS. That is the law now so far as the Federal Government is concerned?

Mr. CHRISTENSEN. Right.

Senator CURTIS. That is all, Mr. Chairman.

Senator BENNETT. May I have 1 more minute, Mr. Chairman? I want to say to Dr. Catchings that we will carefully study these recommendations in your statement regarding the peer review concept and we will include as many of them either in the language or in the report as we can, consistent with the basic principle of the idea.

Dr. CATCHINGS. Thank you.

Senator BYRD. Thank you, Mr. Chairman. Just one question of Dr. Catchings.

What has been the experience of the dental profession with the fluoridation program?

Dr. CATCHINGS. With the fluoridation program?

Senator BYRD. Yes.

Dr. CATCHINGS. The fluoridation program has gone over well in most of the larger communities of the country. We find that we do have forces that oppose it; forces that are not well grounded or well founded. But in the cities, the larger metropolitan areas where the program is working, we have found that it is working well; the incidence of caries has been reduced greatly and we hope we will continue to expand throughout the Nation.

Senator BYRD. You are convinced that it is a logical and sound thing to do?

Dr. CATCHINGS. Yes sir.

Senator BYRD. I am interested in that. Twenty-five years ago, as a newspaper editor, I championed that cause in Virginia. My dentist friends sold me on the idea and it seemed sound and logical and it has proved out over the years, you feel?

Dr. CATCHINGS. I think in the long run it will be proven conclusively that it is really necessary.

Senator BYRD. Thank you, Doctor.

Thank you, Mr. Chairman.

Senator ANDERSON. Thank you very much.

(The prepared appendixes I and II by Dr. Catchings follow:)

APPENDIX I

RECOMMENDATIONS REGARDING PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

As indicated in the text of the statement presented to the Committee, the dental profession is concerned that Amendment 823 to H.R. 1 does not make adequate provision for the peer review of health services which are provided under the Social Security Act by health practitioners other than physicians. Nor does it accord any representation in the advisory or administrative mechanism for other than physicians. The following amendments would correct these deficiencies and are recommended to the Committee:

Section 1152(e) is amended by inserting after "of his profession." the following: "Nor shall any such organization utilize the services of any individual who is not a duly licensed dentist to make final determination with respect to the professional conduct of any other duly licensed dentist or any act performed by any duly licensed dentist in the exercise of his profession."

Section 1155(b) is amended by deleting "is authorized" and inserting in lieu thereof "is required".

Section 1155(c) is amended by inserting "and other providers" after "to familiarize physicians" and further, by inserting "other providers," after "activities by physicians,".

Section 1155(d)(2) is amended by adding "and dental" after "medical".

Section 1162(b) is amended by deleting subparagraph "(B)" and inserting in lieu thereof the following: "(B) Four members of the health professions, no more than two of whom shall be physicians (one designated by the state medical society and one designated by the state hospital association) and no more than one of whom shall be a dentist who shall be designated by his state dental society; and".

Section 1163(a)(1) is amended by deleting "physicians" and inserting in lieu thereof "members of the health professions".

Section 1163 is amended by deleting paragraph "(b)" and inserting in lieu thereof the following: "(b) Members of the Council shall consist of physicians, dentists and other health practitioners of recognized standing and distinction in the appraisal of health services. A majority of such members shall be physicians and dentists who have been recommended to the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians and dentists. The membership of the Council shall include physicians and dentists who have been recommended for membership on the Council by consumer groups and other health care interests."

APPENDIX II

EXCERPTS FROM: AMERICAN DENTAL ASSOCIATION GUIDELINES FOR DENTISTRY'S POSITION IN A NATIONAL HEALTH PROGRAM

Review Procedures

1. Licensed dentists should be involved at all levels of review of the dental aspects in a dental component of a national health program, and review of the quality of professional services should be under the control of licensed dentists.

2. Dental societies should establish effective committees that have consumer representation to ensure accountability to the public. The committees should be well publicized and should provide for discourse between consumers and dentists.

3. Review in a dental component of a national health program should include review of program design and administration, quality of services rendered, fee questions and utilization of services.

4. Continuing review of the design and administration of the dental component of a national health program should include such matters as effectiveness in meeting the dental need of the population, patient utilization, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation and effectiveness of review procedures.

5. Review of quality of dental care in a national program should include review of the quality of services performed, review of the reasonableness of procedures and whether the services were performed in accordance with professional standards.

6. Review of treatment should be performed according to professionally established guidelines through review techniques such as screening of claims, statistical audits, random sampling of records, review of radiographs, random examination of patients and evaluation of complaints.

7. Dental society review committees should be used in the dental component of a national health program for review of professional matters, such as review of services rendered and fee questions.

8. Channels of referral to dental review committees under a national program should be open to the program administrators, dentists, insuring agencies and patients.

9. Appeal procedures for all participants should be provided in the review structure of a national program.

10. A dental review structure, in order to be creditable, must include appropriate sanction against abuse.

11. Effective review procedures should be developed to resolve fee questions, to determine if fees are in accordance with provisions of the program, and to assess whether fees are in fact usual, customary and reasonable when this payment method is used.

12. Effective procedures should be instituted to protect the review committee members.

Senator ANDERSON. Miss Stone?

STATEMENT OF VIRGINIA STONE, CHAIRMAN, EXECUTIVE COMMITTEE, DIVISION OF GERIATRIC NURSING PRACTICE, AMERICAN NURSES' ASSOCIATION; ACCOMPANIED BY CONSTANCE HOLLERAN, DIRECTOR, GOVERNMENTAL RELATIONS DEPARTMENT, ANA

Miss STONE. Mr. Chairman and committee members, I am Virginia Stone, chairman of the Executive Committee of the Division of Geriatric Nursing Practice of the American Nurses' Association. Accompanying me is Constance Holleran, director of the Governmental Relations Department of the American Nurses' Association. Today I appear before you on behalf of the American Nurses' Association and in the interest of time I will summarize the points we have made in our complete statement, which you also have before you.

In relation to the health insurance for the disabled, the association has urged over the years that disabled persons whose incomes are limited, who are likely to require more health services and who experience difficulty in obtaining adequate insurance protection against the cost of health services also be accorded benefits under the medicare program. We urge the members of this committee to approve the action of the House of Representatives.

In relation to the social security retirement benefits, the American Nurses' Association agrees with the increase in benefits effectively, June 1972, and the provision for automatic increases to reflect cost-of-living increases. The liberalization of the amount a beneficiary may earn from the present \$1,680 to \$2,000 without loss of social security income is an improvement although we would have preferred a ceiling of \$2,700. The nurse of retirement age could help meet the health needs of the community in many ways. She or he could give home nursing care, teach home health aides or work in one of many nursing homes which say they cannot secure registered nurses.

As for child-care deductions, the American Nurses' Association has long supported legislation which would liberalize child-care income tax deductions for workingwomen. We are pleased that Congress has provided tax aid for child-care expenses in the new law, Public Law 92-178. Day-care and household help deductions up to \$400 per month are now available to families with a yearly adjusted gross income of \$18,000 or under for the cost of care of children under age 15 and/or invalids.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

As to the professional standards review organization, the American Nurses' Association agrees that provision should be made for utilization review of health services to individuals and peer review to insure that the services are of high quality. Our objection to the proposed professional standards review organization is that it places responsibility for surveillance of utilization and quality almost totally on one profession—medicine—in the health field. It is our contention that each profession within the health field should have the responsibility, and be accountable, for developing standards of care within his/her area of expertness. We submit that review of care in extended care facilities, skilled nursing homes and home health agencies, where the major constant service provided is nursing care, is the responsibility of nurses. In utilization review, we believe the approach should be multidisciplinary, involving representatives of all the health professions. We recommend that National and State professional standards review councils include in their membership representatives of other health professions, in addition to physicians. We also recommend that any organization, established within an area for the purpose of reviewing utilization, effectiveness, and quality of services, be multidisciplinary.

Delegates to the recent White House Conference on Aging recommended and they underscored that comprehensive health care services become available. Services cannot be comprehensive unless all members of the health team are involved in total planning and review.

Medicare and medicaid proposals: The American Nurses' Association takes serious exception to two provisions relating to the medicare and medicaid programs, for we believe they are not in the best interest of patients.

The first provision, section 241, would set up a program to determine qualifications for certain health care personnel who do not have educational credentials but have on-the-job experience.

I would like to remind you, when State licensure came into being people with work experience were reviewed and educational requirements waived.

Under the present medicare and medicaid regulations that govern extended-care facilities and skilled nursing homes, practical nurses licensed by waiver can be employed. We have no objection to this as long as registered nurse supervision is available. If the intent of the provision in H.R. 1 is to test practical nurses licensed by waiver to determine whether they may assume the role of charge nurse, and we believe this is the intent, we would have serious objections. If this is not the intent, the American Nurses' Association feels it is unnecessary

to include the waived licensed practical nurses in the groupings named in section 241.

It is possible to test in a pencil-and-paper test for factual knowledge; however, it is doubtful if it can effectively assess an individual's level of understanding, ability to engage in interdependent and independent decisionmaking, ability to collaborate effectively with other members of the health team and to coordinate diverse activities in patient care. Because of the complexities of health needs of the aged, provisions should be made to encourage the use of the best prepared health personnel rather than the least prepared personnel.

The second provision we object to is section 267, which would waive the requirement that skilled nursing homes under the medicaid program have at least one full-time registered nurse on the staff when the skilled nursing home is in a rural area. Under the provision, standards would be lowered for people in rural sections of the country.

A real concern of the American Nurses' Association is the lack of clarity of several parts of the proposal which, perhaps, some of the members of this committee could clarify for us.

What is your definition of rural? What proportion of nursing home beds are located in rural communities by such definition? How many rural area facilities are adjacent to medical centers? Is there a true shortage of RN's in such locations? Is there an RN shortage in other facilities in that same area? These last questions are asked because there are indications from several State nurses associations that the major problem is not a shortage of RN's but the fact that the salaries and personnel policies of extended-care facilities are not being reviewed and updated—and they are not competitive.

Recruitment programs are not as vigorous as they might be.

These questions are posed because of the necessity to consider a safe level of care for all older people regardless of the location of the facility.

The American Nurses' Association supports amendments to medicare which would extend coverage to the cost of out-of-hospital prescription drugs; would freeze at the present level of \$50 the amount the covered individual must pay in a given year; would eliminate the requirement in H.R. 1 of daily copayments for the 31st through 60th day of hospitalization. Increasing deductibles and coinsurance could have the effect of screening out individuals most in need of care and early treatment, possibly resulting in a more serious and costly illness.

We are in agreement that requiring a 3-day hospital stay before an individual is entitled to medicare coverage of home health services should be eliminated when care can appropriately and successfully be given at home. Studies have indicated that given the opportunity, old people prefer to remain in their homes.

We are strongly in favor of the establishment of an advisory committee on home health services to assist the Assistant Secretary for Health and Scientific Affairs in the administration of home health services provided under medicare, medicaid, and the maternal and child health program.

We believe home health benefits under the medicare program have been overcontrolled. Intermediaries have made arbitrary decision with respect to the nursing care they will approve for payment. As an ex-

ample, payment will not be paid for prevention of decubitus ulcer or bed sores but payment will be made after that has been developed and is given care.

Since less than 1 percent of medicare expenditures have been used to pay for home health services, it does not appear that the number of home visits have been excessive. It is our opinion that the nursing administration is in the best position to determine the need for services in the home. Nursing in the home and homemaker home health aide services can maintain individuals in their own homes, avoiding crisis situations and serious breakdown that lead to need for the most expensive care.

Again, the delegates to the White House Conference on Aging recommended that services be expended and broadened in the home so that there would be alternatives of care available to the elderly.

The American Nurses' Association agrees with the proposal in section 237, which includes utilization review requirements for hospitals and skilled nursing homes under medicaid and maternal and child health programs. We strongly support the belief that the same high quality of care available to the general public should be given both medicaid and medicare recipients.

In conjunction with the same quality of care given to both medicaid and medicare recipients, the availability of health care to both categories of recipients would not be equal under the proposal in section 232, which deals with the determination of reasonable cost of inpatient hospital services under medicaid and maternal and child health programs.

The American Nurses' Association supports the current reimbursement policy, where States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare. This proposal would probably reduce hospital and home health care costs, but to the detriment of poor people whose access to health services would be greatly curtailed because sufficient medicaid funds would not be available. We oppose the proposal in section 232 for we firmly support the belief that there should not be a double standard, and that medicaid recipients should be eligible for the same benefits as are available to medicare recipients.

I appreciate the opportunity to be here today and present the views of the American Nurses' Association. Thank you.

Senator ANDERSON. Are there any questions?

Senator BENNETT. No questions.

Senator CURTIS. Yes.

The States license nurses, issue the licenses as to who is to be a registered nurse; is that right?

Miss STONE. That is right.

Senator CURTIS. Medicare was enacted to help people meet the financial burden of their illness and it was not enacted for the purpose of transferring to Washington the direction and control of all the various medical professions; and it is creating havoc in the country. To have life and death over the continuation of a hospital being determined at Washington just does not make sense at all.

On a different subject, I have a very well-qualified doctor in one of our Nebraska communities who has done considerable work on a paper on further utilizing the visiting nurse as a means not only of serv-

ing the patients much better but also very materially cutting down the costs of medicare and medicaid.

If I delivered that paper to you, would you furnish us with your comments on his proposal?

Miss STONE. We would be delighted, sir.

Senator CURTIS. He points out a number of specific cases where a patient needs to have something done—a check made—it may be a blood test or it may be something else—and if you get an ambulance and send the patient to the hospital it is part of medicare expenses; but if they use a visiting nurse to do that very thing it is not covered.

Are you familiar with any of those problems?

Miss STONE. Yes, sir; I think we also have to keep in mind what it does to the old person to move them from one facility to another if the service could be rendered at home instead.

Senator CURTIS. Yes; he cites a number of important illustrations; he said in one situation a man 70 years-of-age had a pacemaker device inserted in his heart and when he was returned from the hospital there was no provision for a visiting nurse checking him periodically—pulse and just a few other things—to see if the pacemaker was working all right; and the only way he can get it taken care of is to go back to the hospital.

Miss HOLLERAN. One of the serious problems the home health agencies are facing right now, Senator, is that frequently the fiscal agent who reviews the service rendered has disallowed reimbursement, indicating it is not skilled nursing care. The decision is being made at that level. Many of the home health agencies are in serious financial difficulties because they cannot collect for the kind of care they need to provide.

Senator CURTIS. Who said it was not skilled?

Miss HOLLERAN. Those reviewing it.

Senator BENNETT. Blue Cross/Blue Shield.

Miss HOLLERAN. Frequently they say—

Senator CURTIS. Who is they?

Miss HOLLERAN. The agents that review the claims.

Senator CURTIS. For the Federal Government?

Miss HOLLERAN. Right.

Senator CURTIS. For the Federal Government?

Senator BENNETT. Insurers.

Senator CURTIS. That is what I had in mind in my earlier remark. We did not enact medicare to have the Federal Government run the health professions or the hospitals; the States do that and the purpose of medicare is to—like any other insurance company—relieve people of their medical financial difficulties.

You feel if it had not been for those regulations the visiting nurses and other nurses could have rendered a service that would have been very beneficial to the patient as well as saved expense?

Miss HOLLERAN. Yes; and frequently the service has been provided but the reimbursement has not been available.

Senator CURTIS. Well, Mr. Chairman, I would like to ask that the statement entitled "A New Look at the Visiting Nurse," by Dr. Paul Hoff, of Seward Clinic, Seward, Nebr., be inserted in the record.

Senator ANDERSON. Without objection, it will be done.

Senator CURTIS. I will get you a copy and I will ask further if these witnesses wish to make any comment after they have had time to study this, that it go in the same place in the record. That is all.

Senator ANDERSON. Thank you very much.

(The prepared statements of Virginia Stone, Constance Holleran, and Dr. Hoff and comments of Constance Holleran on Dr. Hoff's statement follows. Hearings continue on p. 2434.)

PREPARED STATEMENT OF VIRGINIA STONE, R.N., PH. D., AMERICAN NURSES' ASSOCIATION

I am Virginia Stone, Chairman, Executive Committee of the Division of Geriatric Nursing Practice of the American Nurses' Association, and Director, Department of Graduate Studies, Duke University School of Nursing, and President, North Carolina Nurses' Association. Accompanying me is Constance Holleran, Director of the Government Relations Department of the American Nurses' Association. I appear here today, representing the American Nurses' Association, the professional association of registered nurses in the United States, to speak to certain provisions in H.R. 1, the Social Security Amendments of 1971.

The American Nurses' Association has supported the provisions of the Social Security Act and extensions and improvements in the system since its adoption. It was the first organization in the health field to lend support for proposals to provide health insurance coverage for the aged through the social security mechanism.

HEALTH INSURANCE FOR THE DISABLED

The Association has urged over the years that disabled persons also be accorded benefits under the Medicare program. The disabled have limited income, are likely to require more health services and, in addition, experience difficulty in obtaining adequate insurance protection against the costs of health services. We are in agreement with the House that the "unmet need for health insurance protection among the disabled—is so great that this extension of protection under Medicare should not be put off any longer."¹ We urge the members of this Committee to approve the action of the House of Representatives.

SOCIAL SECURITY RETIREMENT BENEFITS

We approve the increase in benefits effective June 1972 and the provision for automatic increases to reflect cost of living increases; the liberalization of the amount a beneficiary may earn from the present \$1,680 to \$2,000 without loss of social security income, although we would have preferred a ceiling of \$2,700. A higher ceiling would be an inducement to many, nurses included, to return to work, at least on a part-time basis. Registered nurses are in short supply. It would seem that the nurse of retirement age could help meet the health needs of the community in many ways; for example, by giving home nursing care, teaching home health aides, or teaching in one of the pre-vocational health training programs or working in nursing homes which say they cannot secure registered nurses.

CHILD CARE DEDUCTIONS

The American Nurses' Association has long supported legislation which would liberalize child care income tax deductions for working women.

The Association is pleased with the new law, P.L. 92-178, the Revenue Act of 1971, and the included provision dealing with tax aid for child care expenses. Day care and household help deductions up to \$400 per month are now available to families with a yearly adjusted gross income of \$18,000 or under for the cost of care of children under age 15 and/or invalids.

While we are dealing with the subject of child care, there is another aspect of this problem that has not previously been dealt with. Unlike teachers, social workers, and most other health professionals, the services of registered nurses, practical nurses, nurses' aides are required around-the-clock, 24 hours a day, seven days a week. This means that not only are child care services needed dur-

¹ Social Security Amendments of 1971. Report of the Committee on Ways and Means on H.R. 1, House Report 92-231.

ing the day, but in the evening and during the night. Practical nurses and nurses aides have the same needs. Hospitals, skilled nursing homes, and extended care facilities currently suffer a shortage of these categories of manpower. There are many indications that the needed manpower does exist and would join the work force if the range of child care services was considerably expanded. We should recognize, too, that in many circumstances fathers have the need for child care services, if they are to work as well.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The American Nurses' Association agrees that provision should be made for utilization review of health services to individuals and peer review to insure that the services are of high quality. The present practice whereby fiscal intermediaries and public officials make the decisions about the use of services and the kind of care that will be covered has resulted in some arbitrary decisions not related to an individual's need for care. This has been especially noted by home health agencies, and has resulted in hardship both to the agency and the person requiring care.

Our objection to the proposed professional standards review organization is that it places responsibility for surveillance of utilization and quality almost totally on one profession in the health field. For example, the proposed national Professional Standards Review Council would be composed only of physicians. The proposed Statewide Professional Standards Review Councils would also be dominated by medical practitioners. Provision is made for health practitioners to be appointed to State Advisory Groups.

Further, the P.S.R.O. is charged with the responsibility for review of the professional activities of all health care practitioners and of institutions and agencies providing health services.

It is our contention that each profession within the health field should have the responsibility, and be accountable, for developing standards of care within his area of expertness. Obviously, the physician has the expertise to make judgments about the need for medical care and the quality of that care. Other health professionals, including nurses, are the most competent to make the judgments within their area of practice. In extended care facilities, skilled nursing homes and home health agencies, the major constant service provided is nursing care. We submit that review of that care is the responsibility of nurses. In assessing the quality and totality of health care we believe there should be a collaborative effort of all the health disciplines involved.

In utilization review we believe the approach should be multi-disciplinary, involving representatives of all the health professions. The interests of the individuals needing services will be better served when the knowledges of a diverse group are brought to bear on an issue or problem.

We, therefore, recommend that national and state professional standards review councils include in their membership representatives of other health professions, in addition to physicians. We also recommend that any organization, established within an area for the purpose of reviewing utilization, effectiveness and quality of services be multi-disciplinary.

MEDICARE AND MEDICAID PROPOSALS

There are two provisions relating to the Medicare and Medicaid Programs with which we take serious exception because we believe they are not in the best interest of patients.

The first provision, Section 241, would set up a program to determine qualifications for certain health care personnel who do not have educational credentials but have on-the-job experience. In all states there is provision for the licensing of practical nurses. When these laws are initially enacted many individuals without formal preparation were licensed by waiver. The requirements for such licensure varied from state to state. In some, practical nurses took the national examination, called the state board test pool examination; in others, an examination developed by the licensing authority; in others, the license was granted without examination.

Whatever the circumstances, the license issued by waiver is valid and cannot be revoked or suspended without just cause and evidence that the practical nurse has violated the law. He or she can be employed but state law does stipulate that the individual work under the supervision of a registered nurse.

Under the present Medicare and Medicaid regulations that govern extended care facilities and skilled nursing homes, practical nurses licensed by waiver can be employed. We have no objection to this as long as registered nurse supervision is available.

However, if the intent of the provision in H.R. 1 is to test the practical nurse licensed by waiver to determine whether she may assume the role of charge nurse, and we believe this is the intent, we would have serious objections.

A charge nurse is responsible for the total nursing care activities in a facility. Supervision of total nursing care is based on judgments which can only be made as a result of knowledge acquired in an appropriate educational program. Graduates of schools of practical nursing or waiver applicants are not taught nor expected to plan, direct, or supervise patient care. Most laws stipulate that they practice *practical* nursing under the direction of a licensed physician or registered nurse.

The practice of geriatric nursing involves a sequential process including:

(1) the assessment of nursing needs of older people based upon the following factors:

The chronological age and effect of the aging process,

The multiplicity of the aged person's losses: social, economic, physiologic and biologic,

The frequently atypical response of the aged to disease, coupled with the different forms disease entities may assume in the aged person,

The accumulative disabling effect of multiple chronic illnesses and/or degenerative processes,

Cultural values associated with aging and social attitudes toward the aged, and

Finally, the uncertainty of his remaining life span and the increasing possibility of his death.

(2) planning and implementing nursing care to meet these needs; and

(3) evaluating the effectiveness of such care to achieve and maintain a level of wellness consistent with the limitations imposed by the aging process.

This content is not encompassed in educational programs preparing practical nurses and it is exceedingly doubtful that the LPN licensed by waiver would have acquired this knowledge and these skills through experience.

It is possible to test in a pencil and paper test for factual knowledge. However, the effectiveness of a proficiency test to determine level of understanding, the ability to engage in interdependent and independent decisionmaking, the ability to collaborate effectively with other members of the health team and coordinate diverse activities in patient care is doubtful, no matter how well the test is constructed.

We are all concerned that people in extended care facilities and skilled nursing homes receive nursing care that is of high quality. The most effective way to assure this is through professional supervision and continuing education of all nursing personnel.

The second provision we object to is Section 267, which would waive the requirement that skilled nursing homes under the Medicaid program have at least one full time registered nurse on the staff when the skilled nursing home is in a rural area.

A facility without a registered nurse on the staff is not providing skilled nursing care. We do not believe that tax monies should be used to perpetuate poor standards of nursing care. Requirements for safe care should be the same for all people. Rural people would not have the same quality available under this provision. When the Social Security Amendments of 1965 were enacted with provisions for Medicare and Medicaid, Congress did indicate its interest in the provision of health services of high quality.

In May, 1971, the General Accounting Office's Report to the Congress on *Problems in Providing Proper Care to Medicaid and Medicare Patients in Skilled Nursing Homes* concluded: "There is a direct relationship between HEW requirements for skilled nursing homes and the provision of proper care. Deficiencies in meeting these requirements should be a clear warning that patient health and safety may be in jeopardy and that many homes, particularly those having inadequate nursing service and those involving infrequent physician's visits, are not capable of providing the level of skilled nursing care that patients require."

In June, 1971, President Nixon, in his speech to the National Retired Teachers Association and the American Association of Retired Persons, stated: "If there's

any single situation in this country that symbolizes the tragic isolation and shameful neglect of older Americans . . . it is the substandard nursing home, and there are some. I don't believe Medicare and Medicaid funds should go to substandard nursing homes in this country and subsidize them."

Health care facilities facing the problem of lack of qualified registered nurses in the area should step up their recruitment program and review their salary and personnel policies so that they are competitive. States unable to meet the requirements should take a look at and perhaps revise the system of health care services. If the old and the poor are either unwilling or unable to seek medical attention in a distant city, the most logical answer would be to bring the health care services to them, rather than lowering standards and perpetuating unsafe and questionable health care practices.

The American Nurses' Association supports amendments to Medicare which would extend coverage to the cost of out-of-hospital prescription drugs; would freeze at the present level of \$50 the amount the covered individual must pay in a given year; would eliminate the requirement in H.R. 1 of a daily co-payment of \$7.50 by beneficiaries for the thirty-first through the sixtieth day of hospitalization.

The Medicare program was intended to relieve elderly persons on a fixed income of the anxiety of meeting health care costs at a time of life when illness and disability are more likely to occur. Increasing deductibles and co-insurance could have the effect of screening out individuals most in need of care and early treatment, possibly resulting in a more serious and costly illness.

We are in agreement that the requirement of a three day hospital stay before an individual is entitled to Medicare coverage of home health services should be eliminated when care can appropriately and successfully be given at home.

Health insurance in this country, whether provided through public or private mechanisms has encouraged the use of the most expensive facilities for the provision of care. The requirement of three days hospitalization prior to home care perpetuates this practice. We urge that it be removed.

We support also the establishment of an advisory committee on home health services to assist the Assistant Secretary for Health and Scientific Affairs in the administration of home health services provided under Medicare, Medicaid and the maternal and child health program.

For the record, we would like to state that we believe home health benefits under the Medicare program have been over-controlled. Intermediaries have made arbitrary decisions with respect to the nursing care they will approve for payment. To be sure their decisions are based on regulations of the Social Security Administration that are perhaps interpreted rigidly. On the other hand, the limitations on home health services in the regulations need to be reconsidered. Agencies providing these services have a long history of controlling their activities and unnecessary visits by nursing staff have been discouraged. Supervision of staff is of a high caliber. Case conferences on patient needs and evaluation of the service provided is a long established practice in these agencies. Since less than one percent of Medicare expenditures have been used to pay for home health services, there is some justification in believing the agencies are not given to overvisiting for the sake of the Medicare dollar. It is our opinion that the nursing administration is in the best position to determine the need for services at the home.

Traditionally, health insurance, whether provided through public or private mechanisms, has encouraged the use of the most expensive facilities and providers, resulting in over-utilization of these and contributing to an inflationary trend in costs. Nursing in the home and homemaker/home health aide services can maintain individuals in their own homes, avoiding crisis situations and serious breakdown that lead to need for the most expensive care.

The American Nurses' Association is in accord with the proposal in Section 237 to include utilization review requirements for hospital and skilled nursing homes under Medicaid and maternal and child health programs. We have always supported the belief that the same high quality of care available to the general public should be given both Medicaid and Medicare recipients.

The American Nurses' Association is opposed to the proposal in Section 232, which deals with the determination of reasonable cost of inpatient hospital services under Medicaid and maternal and child health programs. The organization supports the current reimbursement policy, where states are required to reimburse hospitals for inpatient care under Medicaid on the basis of the reasonable cost formula set forth in Medicare. This reasonable cost formula allows for

more care to be available to more poor people, and we believe this was the intent of Congress. Under this new proposal in Section 232, hospital and home health care costs would probably be reduced, but to the detriment of poor people whose access to these health services would be greatly curtailed because sufficient Medicaid funds would not be available. We firmly support the belief that there should not be a double standard, and that Medicaid recipients should receive the same benefits as are available to those covered by Medicare.

Finally, the American Nurses' Association does not agree with Section 265 which specifies that provision of medical social services would not be required as a condition of participation for an extended care facility under the Medicare program. As a professional group, we recognize the contribution that social work has made in assisting the aged and in working with nurses and other health professionals to improve conditions in nursing homes. It is the professional social worker who is fully qualified to attend to the medically related social problems of patients. It is this professional social worker's participation in staff training programs, case conferences, and orientations to community services which enables all of us, as a professional multidisciplinary team, to best meet the health needs of this segment of our population covered by Medicare.

As a member of the largest group of professional people giving health care and who are deeply concerned with the health of the American people, I appreciate the opportunity to appear here today to present the views of the American Nurses' Association.

STATEMENT OF THE AMERICAN NURSES' ASSOCIATION, INC., SUBMITTED BY CONSTANCE HOLLERAN, DIRECTOR, GOVERNMENT RELATIONS

STATEMENT ON CATASTROPHIC HEALTH INSURANCE

The position of the American Nurses' Association is that health care is a basic right of all people. Government has a responsibility for assuring through appropriate legislation that all people have equal access to such care.

We believe the health care provided should be comprehensive and consist of preventive, health maintenance, diagnostic and treatment, restorative and protective services.

The association believes that any system of national health insurance that is initiated should provide these comprehensive services. Provision should also be made in such a program to help meet the costs of a catastrophic illness which can indeed have unfortunate economic consequences for an individual or family.

Therefore, we would prefer to have catastrophic health insurance as one element in a comprehensive program. Catastrophic illness can be the result of lack of preventive and diagnostic services and of easy access to facilities and health professionals. Payment for preventive and diagnostic services and a shift to the use of ambulatory services—clinics, out-patient departments, the home, neighborhood health centers could have an influence on the incidence of catastrophic illness.

Additional public and private financing of health care services alone will not guarantee that health care is accessible to all. If the health care benefits are not comprehensive the consumer will be further encouraged to seek care only in crisis situations.

Of course, as nurses, we are intimately aware of the financial hardships and at times financial disaster of families of those with a catastrophic illness. Assistance to such families is, of course, needed. What is catastrophic to one family is not to another so the conditions for eligibility must be adjusted to size of family, income, length of illness (long term care at a lower cost than crisis care can still be catastrophic) loss of earning power and other factors.

A NEW LOOK AT THE VISITING NURSE

(By R. Paul Hoff, M.D., Seward Clinic P.C., 311 Jackson Street, Seward, Nebr.)

You are 75 years old and live in a nursing home. Your sight is very poor and your arthritis painful. You are diabetic and have been given 20 units of insulin every day for the past four years. No laboratory tests have been

done in those four years to check to see if you are still taking the correct dosage of insulin. What about those odd dizzy spells that come out of nowhere? Medicare will not pay to have you admitted to the hospital overnight for diagnostic work. There is no doctor in the town where you live and your arthritis will not allow you to ride in a car to the town where there is one.

You are 67 years old and have been in poor health for several years. As a result, you have been on welfare for those years. Coumadin therapy is necessary to treat your condition, and it is very important that the Coumadin level in your blood be checked occasionally. For you, this means a trip to the hospital or the doctor's office by ambulance. Welfare will not allow this expense.

Your husband is 70 years old and has just had a pacemaking device inserted into his heart. This is your first day at home alone with him since he came home from the hospital. The last few weeks have been so frightening. Do you remember just what the nurse and doctor told you about checking your husband's pulse and the signs of trouble to watch for? You hate to bother the doctor, but it would be so reassuring to talk with someone about your husband's care.

We met situations like these just last summer when a town of about 1,300 people fifteen miles south of our town lost their doctor. This town has no hospital, but does have two nursing homes; one with a 120-bed capacity and the other with a 65-bed capacity. These elderly patients plus a number of others living alone in their homes presented a long list of problems. How could these people be given good medical care and service staying within the framework of services allowed by Medicare, the County Welfare Department, and the private insurance companies? We feel we have found a way to do this and have, in fact, been doing this for six months, but Medicare and welfare have *disallowed payments*.

About two years ago, our hospital began an intensive and coronary unit that has been received by the nursing personnel with great enthusiasm. Of the 30 registered nurses who work at the hospital, 18 have voluntarily taken a full course in coronary care nursing. They are also trained in using IPPB apparatus, resuscitative procedures, and taking blood for laboratory studies. Among these nurses was a young woman who had formerly been the assistant to the nursing supervisor at the hospital. Because of her family, she did not wish to work on a full-time basis and was working part-time last summer.

Would it be possible for our office to hire this capable nurse to be a "visiting nurse" to the town without a doctor? She would certainly not be a "visiting nurse" in the old sense; bed baths, enemas, and backrubs would not be her forte. On her weekly visits to this town she might find herself running an electrocardiogram, drawing blood to be sent to a laboratory and making a call in a home to observe and reassure a patient recently dismissed from the hospital. We began to plan.

The patients who would benefit most seemed to fall into two broad categories; (1) Those who are bedfast or incapacitated in some way that makes travel by automobile very difficult and (2) Those who have recently been dismissed from the hospital. Any of these patients might need blood drawn for "blood thinning" therapy or follow up for other drug administration. A visit by this nurse to the coronary patient newly home from the hospital could be very beneficial and reassuring. Diet and medications could be discussed again and the home observed for any factors that might be harmful to the patient. While in coronary care, relatives often are not thoroughly briefed on their responsibilities when the patient is dismissed. We like to get our patients home as soon as possible. This in turn is a saving to the patient, his insurance company and/or Medicare or county welfare.

A new mother just home with her firstborn child would certainly benefit from a visit by this nurse. The new mother may have felt when she was in the hospital that she had her instructions well in her mind but after a nearly sleepless night or two, she would probably welcome a refresher course and some reassurance. The visits by this nurse were not meant to replace the usual appointments to the doctor's office made for those dismissed from the hospital. In some cases an earlier dismissal from the hospital is possible when it is known that the patient will be observed at home in a few days. Neither would the visit of the nurse to the bedfast or incapacitated eliminate the need for calls by the doctor at times. With the observations by the nurse and the result of the tests performed by her or with her help, a judgment could be made about the need for the patient to be seen by the doctor or hospitalized.

Recently, there have been a number of articles written about the development of medical assistants in the rural areas to help the general practitioner. We needed an idea that we know would work and that we could begin to use *right away*.

The Visiting Nurse Association in the state capitol and the Medicare office for the state were contacted for their opinion. It seems that no program like this has been initiated in the state. No encouragement or discouragement were found, only the comment, "it has never been done."

The fee to charge for the visit of this nurse was a problem that took careful consideration. At first we thought we would charge mileage plus a charge for whatever service she performed. The Home Health Care Service in the state capitol charges \$7.50 for a call by one of their nurses, plus medications or any extras. However, this is strictly a nursing service. We decided to charge \$6.00 per visit by the nurse, plus any laboratory or medications to be charged as usual.

Our new visiting nurse program has now been in operation over six months. The result has been very pleasing. Our nurse has been met with enthusiasm by people in nursing homes and in their own homes; and she, herself, enjoys this new job and looks forward to continuing in this capacity.

We would like to mention some of the interesting cases we have found in the six months we have operated this program.

In one of the nursing homes we found a little elderly lady who was deaf and almost totally blind and confined to bed. She had been on 20 units of NPH insulin for the past four years without having had a blood sugar evaluation during this time. Blood sugar tests were done and after evaluation she was placed on 55 units of insulin daily. This lady is now much more alert and able to be up and about with help. She must have been bordering on diabetic acidosis before her insulin was increased.

Several cases were found where the patient has been on a digitalis preparation for a long time. After electrocardiograms were taken it was found that these patients were in heart block. The digitalis was either discontinued or enhanced in some way to improve the patient's condition.

There is a grand gentleman who has been a paraplegic for many years due to a spinal injury, who has been visited by our nurse. He is in his home and cared for by his wife. He has osteoarthritis, and scoliosis and lordosis of his back. He was hospitalized two years ago with a broken leg. He has an indwelling catheter and has intermittent bladder infections that are controlled if caught early. He is diabetic. He is able to get around in a walker, built-up shoes and braces; but getting down the steps from his home, into his car, out of his car and into our office to have blood drawn for laboratory tests is often more than he can tolerate. It has been so successful to have our nurse call this man and tell him not to eat until she gets to his home the next morning. She draws the blood for the laboratory and takes it to our office where we run the blood sugar and call him if he needs to change his medication or diet. Cost comparison: \$11.00 total if he is seen in the office \$12.00 if the nurse visits. Medicare has allowed neither the nurses calls nor the laboratory fee, yet they would pay the entire fee in the office.

A physician from our office recently made a rushed trip to the town 15 miles south to examine an elderly woman found unconscious in her home. By the time he arrived she had regained consciousness. After a brief examination he decided that she needed further evaluation. She flatly refused to be hospitalized or to take the 15 mile trip to be seen in the office. She did agree to allow our nurse to visit her in her home and take an electrocardiogram and draw blood for laboratory work. While doing the electrocardiogram, our nurse found a large firm, indented mass in the lower quadrant of this woman's breast. When confronted with this situation, she did finally agree to have a mastectomy. Had it not been possible to comply with this woman's wishes and allow her to have tests taken at home, she might have refused examination altogether which would have resulted in her tumor eventually forming a draining wound that would have caused her great misery, plus long-term hospitalization at the expense of Medicare and family. In our opinion, because of this program, Medicare was probably saved enough to fund our whole program for a year!

We have puzzled over the past two years as to the cause of an idiopathic anemia in two gentlemen, one in a nursing home in the town 15 miles to the south and the other in a nursing home in our town. We have had adequate consultations with no answers as to etiology. Until we find the cause, we must treat the symptoms. This means periodic hemoglobin determinations (blood tests)

and the administration of blood transfusions when the red blood count gets too low. Both of these men are very frail, one of them being completely blind and partially deaf. It is helpful to have our nurse visit them and draw blood for their laboratory tests. The only other alternative is to have them transported by ambulance at least once or twice a month to the hospital at a total cost of well over \$50.00 per trip.

Obviously, as well as being a service bringing better medical care to people, we feel our program is cutting costs to the taxpayer.

A couple was having difficulty conceiving. They put in for adoption. Three months later they were called to come and get their *infants*. That's right, *twins*. They were tickled pink . . . but also frightened. They were not used to children after nine years of marriage and to suddenly have two less than 10 days old was "a little much." Examination and consultation in our office by the doctor was followed in three days with a home visit by our nurse. The new mother has mentioned at least three times how much this meant to her and what a tremendous boost it gave her. Money saved?—none—worry, sleep, saved?—how do you start to measure?

An elderly county patient in the nursing home 15 miles to the south of our town recently had an embolectomy. She recovered from the surgery, but would ordinarily have been kept in the hospital a rather long time as she was on Coumadin therapy and needed to have blood tests every few days to be sure she was on the correct dosage of Coumadin. Due to our program, she was able to be dismissed to the nursing home soon after surgery; her blood was checked by the nurse in the nursing home. There was undoubtedly quite a difference between the bill to Medicare for this lady. Thirty to forty dollars per day versus six dollars every week plus the laboratory fee for the visits by our nurse in the nursing home.

The list could go on and on, but the reader should be getting the idea by now!

Here are a few quotations from a booklet prepared by the American Medical Association, American Hospital Association, American Public Health Association, American Public Welfare Association, Blue Cross Association, National Association of Blue Shield Plans, National League for Nursing, and the Public Health Service.¹

(1) "As a home care program is developed it should be planned to eventually provide service to *all patients* residing in the area who would benefit from the program. To be effective, a home care program should be operated in a manner that preserves traditional physician-patient relationships;

(2) A home care patient, in general, is one whose needs and home and family situation are such that the care he requires can be provided most appropriately in his place of residence. Visits to a physician's office, clinic, or hospital outpatient department *are not feasible* or cannot meet all his medical care needs. He does not need professional observation and treatment 24 hours a day and the nursing and other therapeutic services his doctor prescribes may be brought to him on an intermittent basis, with good results;

(3) The home is not appropriate for all chronically ill patients in all stages of their illness. It can, however, be the most desirable setting for many more patients than are currently served; and

(4) This guide which deals with the development of coordinated home care programs recognizes the existence of other guides for the development of home care services. It does not, in any manner, attempt to standardize or stereo-type home care programs."

Our experience to date, however, is that unless it is a stereo-typed "public-health" type program it is doomed to failure because it will not be accepted by Medicare.

I hope that the fact that this is an idea that originated in an area other than a metropolitan medical center, without the use of public funds for development, will not preclude its use as one way to help the elderly and shut-ins get the care they deserve. However, it must be recognized and accepted by the welfare and Medicare organizations.

To date, they have not only disallowed the fee for nurses visits, but also the laboratory and electrocardiogram fees. (The very same procedures that are fully allowed in our office or hospital.) We are currently about \$2,000.00 in the

¹ Guide for Development and Administration of Coordinated Home Care Programs, Public Health Service Publication No. 1579, December, 1966.

red on our program because we have picked up the tab for the nurse and paid for laboratory and electrocardiogram interpretations sent to independent laboratories and cardiologists. We cannot continue this independently. Hopefully these agencies will change their rules and reimbursement will be allowed.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., February 7, 1972.

Senator CARL T. CURTIS,
U.S. Senate,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR CURTIS: I have reviewed as you requested the paper "A New Look At The Visiting Nurse" by R. Paul Hoff, M.D. of Seward Clinic, Seward Nebraska and I think he has very clearly pointed out both the potential for service and the problems in obtaining reimbursement, for home nursing care. Visiting Nurse Associations have been providing such services for a long time. The problem with federal reimbursement for services for "skilled nursing care" has been a serious one for many of these home health agencies. Financial disaster is facing many of them that provide services such as those described by Dr. Hoff and they cannot be reimbursed, as the person reviewing the claim says the service is not "skilled nursing."

I am happy to have had the opportunity to read Dr. Hoff's article. He is correct that in the long run money could be saved and patients needing care would be happier and better served. Professional nursing judgment is allowed to decide which nursing services should be provided under various federal health programs.

We hope we can count on your support on this important issue.

Sincerely yours,

CONSTANCE HOLLERAN,
Director, Government Relations.

Senator ANDERSON. Dr. Wiggins?

STATEMENT OF JACK G. WIGGINS, PSYCHOLOGIST, CLEVELAND, OHIO, MEMBER, BOARD OF GOVERNORS, COUNCIL FOR THE ADVANCEMENT OF PSYCHOLOGICAL PROFESSIONS AND SCIENCES (CAPPS), AND EXECUTIVE COMMITTEE; ACCOMPANIED BY A. EUGENE SHAPIRO, DIPLOMATE, CLINICAL PSYCHOLOGY, CONSULTANT IN PSYCHOLOGY, ST. MICHAELS HOSPITAL, NEWARK, N.J.

Dr. WIGGINS. Mr. Chairman and members of the committee, I am Dr. Wiggins, a psychologist from Cleveland, Ohio. I am accompanied by A. Eugene Shapiro of New Jersey. We would like to submit our written statements for the record and confine our oral remarks to excerpts from our written statements.

Senator ANDERSON. Without objection, that will be done.

Dr. WIGGINS. Thank you.

We generally have a favorable reaction to the intent of H.R. 1 and would like to restrict our comments to the utilization of psychological services.

I have asked Dr. Shapiro to share this time with me and if he may make some introductory remarks, please. Dr. Shapiro?

Dr. SHAPIRO. By way of introduction, I am Dr. A Eugene Shapiro, a diplomate in clinical psychology, and I have been in private practice for close to 20 years. I am a consultant in psychology to St. Michaels Hospital in Newark, N.J., a general hospital, and I have a staff

appointment to another general hospital, the Newark Beth Israel Medical Center.

I have also been involved with the professional affairs of psychology. I have been chairman of the insurance committee of the State of New Jersey. I have been on the committee of health insurance and am currently serving on the American Psychological Association and am on the board of directors of the New Jersey Psychological Association.

In general, what I would like to communicate, as I leave my notes and share some thoughts with you for the sake of brevity, is the concept that is stated on page 6 of the original Medicare and Medicaid Act, Public Law 89-97, which states: "Free choice by patient guaranteed."

It is a short section; it states:

Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services.

We believe strongly that psychologists are independently qualified to provide those services for which they are licensed in 44 States and in the District of Columbia to provide, providing they are functioning within the scope of their practice, within the scope of their license, and providing the service which medicare and medicaid has underwritten.

In principle, we believe every individual has the right to health benefits regardless of age, area of residence, ability to pay, and that the primary determinant should be need for service. But we also strongly believe that those in need of health services should have the right to choose from licensed professionals functioning within the scope of their practice which psychologists by training are well qualified to provide.

All laws that have been passed to regulate the practice of psychologists call for a minimum of a doctorate from a recognized university, internship in an approved setting, and postdoctoral training. We have every evidence to believe that our controls over the profession are sufficient to insure our continued functioning as an independent provider of health benefits.

The effectiveness of the control over our profession and the ethical functioning of psychologists is reflected in the fact that while the cost of malpractice insurance for most medical specialties has continued to rise to astronomical heights as the public has sought redress through the courts, the cost for malpractice insurance for psychologists has continued to decline. At present, a private practicing psychologist can receive professional liability insurance in the amount of \$300,000 to \$900,000 per year for a cost of \$40 per year.

In 15 years that psychologists have had malpractice insurance, there has not been one case that has gone to the courts.

There is significant evidence that suggests that early intervention in the treatment of mental health disorders reduced overall costs of medical expenses. Studies by Cummings and Follette at Kaiser-Permanente clearly show that early intervention and utilization of psychotherapeutic services tend to reduce overall medical costs.

In this connection, we wonder how many aged people are seeing physicians for a variety of physical ailments which really reflect their

need for someone to talk to, someone to listen to them, someone who will give them interest and concern and professional treatment. How many dollars are spent for purported medical care that might be treated less expensively and more productively as a mental health problem?

Surely if any group were to be singled out for having emotional problems concomitant with conditions outside their control, the poor and the aged fit this category.

The committee, I am sure, is concerned always about fiscal matters and costs and I would like to bring your attention to the precedent of the Civil Service Commission in providing health benefits to the civil service employees under the Aetna plan, a major provider for mental health benefits. Psychologists are included as independent providers of mental health services and the experience reported by Aetna has been clearly favorable. As a matter of fact, they have been one of the carriers that have not increased their costs.

The CHAMPUS program for civilians, the civilian health and medical program for uniformed servicemen, covers about 6 million lives of servicemen and their benefits also include psychologists as independent providers of health services. Their recent findings, and I quote Mr. McKenzie, were: "Laudable."

We feel very strongly there should be no limitation in the law that places psychologists licensed in 44 States and ancillary to another profession; namely, medicine, and as such, adds additional costs perhaps to the Government as one gets certified and recertified with no evidence whatever there is any fiscal savings and, in fact, there is considerable evidence that it may add to the costs.

Dr. WIGGINS. Thank you.

I am on the executive committee of the Council for the Advancement of Psychological Professions and Sciences. In addition, I am the chairman of the Committee on Health Insurance of the American Psychological Association, although I am not at present speaking for the APA, which organization will submit a statement to the committee consonant with our testimony today.

The American Psychological Association has 32,000 members and represents both the science and the profession of psychology. About 15,000 of our members are supplying mental health services directly to the public. The remainder of the membership have teaching positions in universities and medical schools, are conducting research or serve in an administrative capacity.

The APA Committee on Health Insurance strives to assure that: high quality mental treatment services are available to the public through their insurance contracts. One of the major objectives of this committee is to remove from health insurance contracts those provisions which interfere with mental health treatment or availability of services. We share this objective in common with the council—CAPPS.

Medicare contains some built-in limitations which restrict the patterns of care and availability of services for individuals suffering from mental, psychoneurotic or personality disorders. While there are provisions for the diagnosis and treatment of mental, psychoneurotic and personality disorders under Part B, they must either be provided by a doctor of medicine or a doctor of osteopathy or incident to his serv-

ices. The result of these provisions has been to restrict the delivery of mental health services to the point that less than 1 percent of the patients served by psychologists are 65 years of age or over.

In effect, this has excluded the diagnostic and treatment service of psychology to recipients of medicare benefits. This is contrary to the intent of H.R. 1, which is to make fullest use of health personnel.

Psychology has established itself as an independent health profession through its training, public acceptance of its services provided and through statutory regulations. Our training leading to the Ph. D. degree and experience at hospitals, clinics and other service facilities has qualified psychologists to provide direct services to the public. Psychologist practice without medical certification, direction or supervision according to professional practice statutes in 44 States and the District of Columbia. In the remaining six States, psychologists practice without medical direction or supervision using voluntary controls.

State legislatures have recognized the inequities in private insurance contracts which have denied the claims of policyholders for the diagnosis and treatment of mental, psychoneurotic and personality disorders when the policyholder was attended by a psychologist. Ten States have now enacted laws which require insurance carriers to reimburse their policyholders for the diagnosis and treatment of nervous and mental disorders whether the services are rendered by a psychologist or a psychiatrist.

To our knowledge this has not resulted in any additional premiums to the policyholders or exceptional increases in utilization. These laws have been well received by the public.

Several insurance carriers, recognizing this inequity, have voluntarily included psychology as a qualified provider of services as a physician for the purposes of their contract for the treatment of mental disorders. Therefore, we believe that continuing the practice of requiring that mental health services for the recipient of medicare be provided only by psychiatrists causes an unnecessary hardship on the beneficiaries of medicare and creates an unnecessary artificial shortage of qualified providers of service for nervous and mental conditions. Failure to include psychological services without medical referral produces a condition of featherbedding physicians' fees. The cost of certification and recertification by doctors of medicine or osteopathy only can require an extra visit to the doctor and produce another fee chargeable to the medicare program.

However, the reality is that because of the cumbersome reimbursement procedure, psychological services are little used and the treatment of the mentally ill becomes a private preserve of organized medicine.

In addition to these potential costs, it must be noted that by reducing the number of providers of services arbitrarily, you create an inflationary imbalance between supply and demand for services. The present restriction upon the availability of psychological services is such an inflationary procedure because it reduces the access of the public to qualified providers of services. This is totally unacceptable to the profession of psychology.

We concur with the American Psychiatric Association; there must be multiple methods of referral.

Furthermore, several studies including those of Drs. Cummings and Follette and the Group Health Association of Washington, D.C., have demonstrated that medical utilization tends to decrease if adequate counseling services are included in health insurance plans. If I may, Mr. Chairman, without unduly burdening the record of these hearings, I would like to introduce at this point in my remarks these studies for the record.

To summarize these studies, they demonstrate that short-term intervention and psychotherapeutic counseling not only reduce diagnostic, X-ray, and laboratory studies but also reduce the incidence of hospitalization. Thus the cost of additional counseling services would be more than offset by the reduction of costs of hospitalization and unnecessary laboratory and X-ray studies.

This has been clearly demonstrated in health maintenance organization. The cost savings in the health maintenance organization's concept tend to be the result of reduction in hospital utilization. We wish to point out that psychological services tend to be outpatient-based rather than hospital-based services. Thus the diagnostic and counseling services of psychology could serve as a deterrent to overutilization of medical services which are already in short supply and hospital beds of which there is a chronic shortage. Our crises intervention studies show that the prompt effective counseling with people tends to reduce the number of people entering mental hospitals, as well.

We believe that utilization control must occur through peer review mechanisms rather than through the source of referral. The profession of psychology has established its own peer review mechanism which is accepted by the health insurance industry.

For the reasons cited, we ask that H.R. 1 be amended so that psychologists will be listed as physicians for the purpose of providing diagnostic and treatment services for mental, psychoneurotic, and personality disorders as well as for the diagnosis and treatment of mental retardation, vocational rehabilitative services, and child care services.

Thank you. This concludes my remarks and if you have any questions we would be glad to respond.

The CHAIRMAN (now presiding). Any questions, gentlemen?

Senator FANNIN. Mr. Chairman, Dr. Shapiro, when you were talking about in 15 years psychologists have had malpractice insurance there has not been one case that has gone to court, are you familiar with a case in Flagstaff, Ariz., a recent case, where there was a malpractice case? I do not know whether it was a psychiatrist or psychologist, but I know there was a case where they had the patient under extreme tension and what they refer to as a fit of rage and she had a heart attack and passed away and there was a lawsuit and about a \$50,000 settlement.

Dr. SHAPIRO. I really do not know. My figures which are relatively recent, indicate no case has come to court. There have been, as you probably know, some types of services generally referred to as encounter groups or that kind of thing which are done by psychiatrists and by some psychologists and apparently there have been cases that have come up because of that.

Senator FANNIN. This is recent and very widely publicized because the license of that practitioner—I do not know whether it was a psychologist or a psychiatrist—but I would like to know because of your

statement here and I will check into this matter and I wish you would, because I would like to be informed.

Dr. SHAPIRO. I am sure we would get our feedback through the association.

Senator FANNIN. I believe the name was Miller but I am not sure of the name. I know it was a recent case and the license of the practitioner was canceled but they were able to get the patient into a very high tension, extreme tension, and caused a fit of rage and a heart attack.

Dr. SHAPIRO. Well, I really don't know and I certainly will look into it. All I know is we right now can get \$300,000 and \$900,000 liability, malpractice insurance, at a cost of \$40 a year.

Now, this is like no experience, so if there have been cases, and even this one, it has not affected my premium rate. If it goes up next year it would be a psychologist; if it does not it was a psychiatrist. But our record has been——

Senator BENNETT. Do you speak to each other?

Dr. WIGGINS. Yes, sir; as a matter of fact, I practice with a psychiatrist; we have a joint practice.

Dr. SHAPIRO. Generally speaking, the roles of psychologists and psychiatrists are quite friendly. Very often we overlap more with one another than they do with their own medical brethren.

Senator BENNETT. This is what I would think.

Senator FANNIN. Thank you.

The CHAIRMAN. Thank you very much, gentlemen.

Dr. SHAPIRO. Thank you.

(The prepared statements with attachments of Dr. Wiggins and Dr. Shapiro and a statement of the American Psychological Association follows. Hearings continues on p. 2479.)

PREPARED STATEMENT AND REPORTS BY DR. JACK G. WIGGINS

Mr. Chairman and Members of the Committee:

My name is Dr. Jack G. Wiggins. I am a psychologist from Cleveland, Ohio and am a member of the Board of Governors of the Council for the Advancement of Psychological Professions and Sciences (CAPPS), and serve on its Executive Committee. One of the objectives of the Council is to insure that there are an adequate number of psychologists available to serve the health and mental health needs of the public and to insure that the public has ready access to psychological services.

In addition, I am Chairman of the Committee on Health Insurance of the American Psychological Association though I am not at present speaking for the APA, which organization will submit statement to the committee consonant with our testimony today. The American Psychological Association has 32,000 members and represents both the science and the profession of psychology. About 15,000 of our members are supplying mental health services directly to the public. The remainder of the membership have teaching positions in universities and medical schools, are conducting research, or serve in an administrative capacity. The APA Committee on Health Insurance strives to assure that high quality mental treatment services are available to the public through their insurance contracts. One of the major objectives of this committee is to remove from health insurance contracts those provisions which interfere with mental health treatment or availability of services. We share this objective in common with the Council (CAPPS).

Medicare contains some built in limitations which restrict the patterns of care and availability of services for individuals suffering from mental, psychoneurotic or personality disorders. While there are provisions for the diagnosis and treatment of mental, psychoneurotic and personality disorders under Part B, they must either be provided by a doctor of medicine or a doctor of osteopathy

or incident to his services. The result of these provisions has been to restrict the delivery of mental health services to the point that less than 1% of the patients served by psychologists are 65 years of age or over. In effect, this has excluded the diagnostic and treatment service of psychology to recipients of medicare benefits. The intent of H.R.-1, according to the House Ways & Means Committee, is to make fullest use of public health personnel. I quote Page 107, Union Calendar No. 86: "Your committee believes that failure to make the fullest use of competent health personnel is of particular concern because of the shortage of such personnel." H.R.-1 does not provide remedy of this shortcoming of the original Medicare Act. Therefore, we are requesting HR-1 amend its definition of the term "physician" to include services of a psychologist for the diagnosis and treatment of mental, psychoneurotic and personality disorders as well as for the providing of diagnostic and treatment services for the mentally retarded, vocational rehabilitative services and child care counseling.

Psychology has established itself as an independent health profession through its training, public acceptance of its services provided and through statutory regulations. Our training leading to the Ph.D. degree and experience at hospitals, clinics and other service facilities has qualified psychologists to provide direct services to the public. Psychologists practice without medical certification, direction or supervision according to professional practice statutes in 44 states and the District of Columbia. In the remaining 6 states, psychologists practice without medical direction or supervision using voluntary controls. The problem in the existing legislation was pointed out eloquently by Senator Harris of Oklahoma in his comments on the Senate floor on November 23, 1967, when the Senate voted to amend the Social Security Act Amendments of 1965 regarding Medicare: "The present defects in existing legislation arise from the fact that two independent but equally well-qualified professions, psychiatry and clinical psychology, offer similar and frequently identical services to the public. However, present regulations require that the services of clinical psychologists be reimbursed only if included in a physician's bill or as part of the charges of a clinic directed by a physician. This restriction denies the patient direct access to the many qualified clinical psychologists who are independent practitioners and unaffiliated with clinics or private physicians."

State legislatures have recognized the inequities in private insurance contracts which have denied the claims of policyholders for the diagnosis and treatment of mental, psychoneurotic and personality disorders when the policyholder was attended by a psychologist. Ten states have now enacted laws which require insurance carriers to reimburse their policyholders for the diagnosis and treatment of nervous and mental disorders whether the services are rendered by a psychologist or a psychiatrist. To our knowledge, this has not resulted in any additional premiums to the policyholders or exceptional increases in utilization. These laws have been well received by the public. Several insurance carriers, recognizing this inequity, have voluntarily included psychology as a qualified provider of service as a physician for the purposes of their contract for the treatment of nervous and mental disorders. Please include such companies as Prudential, Occidental, Liberty Mutual, and Massachusetts Mutual. The Aetna Life & Casualty Insurance Company has included psychologists as qualified physicians under the mental health benefits for its federal employees contract. Another form of similar recognition of psychological services was initiated by the Civilian Health & Medical Program for Uniformed Servicemen (CHAMPUS) in July, 1970. Mr. Vernon McKenzie, Special Assistant to the Asst. Secretary for Health and the Environment of DOD, stated before the Senate Post Office and Civil Service Committee on November 23, 1971 that the inclusion of psychological services without medical referral has been well received by the dependents of military servicemen.

At the inception of Medicare, there was considerable concern about overutilization of services and it was felt that one of the cost control factors would be that all services would be at the direction or incident to a physician's services. The experience of private insurance carriers in regard to inclusion of psychological services for the treatment of nervous and mental disorders has indicated that this provision has not materially affected their cost experience. Therefore, we believe that continuing the practice of requiring mental health services for the recipients of Medicare be provided only by psychiatrists causes an unnecessary hardship on the beneficiaries of Medicare and creates unnecessary artificial shortage of qualified providers of service for nervous and mental

conditions. In fact, failure to include psychological services without medical referral, in effect, produces a condition of "featherbedding" physician's fees. The cost of certification and recertification by doctors of medicine or osteopathy only can require an extra visit to the doctor and produce another fee chargeable to the Medicare program.

However, the reality is that because of the cumbersome reimbursement procedure, psychological services are little used and the treatment of the mentally ill becomes a private preserve of organized medicine. In addition to these potential costs it must be noted that by reducing the number of providers of services arbitrarily, you create an inflationary imbalance between supply and demand for services. The present restriction upon the availability of psychological services is such an inflationary procedure because it reduces the access of the public to qualified providers of service. This is totally unacceptable to the profession of psychology. We concur with the American Psychiatric Association that this results in unnecessary delays in treatment which in the long run may be more costly and damaging to the patient. The American Psychiatric Association in their testimony submitted to the House Ways & Means Committee on National Health Insurance in November, 1971 stated as follows:

"With reference to the psychiatric services that should be covered, the APA Board of Trustees stressed its opposition to any provision whereby psychiatric care would be covered under insurance only when such care is received upon referral by the family physician or general practitioner. We based this opposition on the grounds that such a provision is not compatible with early detection of psychiatric illness and easy access to psychiatric care. Experience indicates the necessity for direct accessibility of the patient to such care and for multiple mechanisms of referral. Self-referral, frequently upon the suggestion of the foreman, teacher, or clergy, or referral by a community agency frequently leads to early diagnosis and treatment, and may prevent or reduce the disability that might otherwise occur."

Furthermore, several studies including those of Drs. Cummings and Follette and the Group Health Association of Washington, D.C. have demonstrated that medical utilization tends to decrease if adequate counseling services are included in health insurance plans. If I may, Mr. Chairman, without unduly burdening the record of these hearings, I would like to introduce, at this point in my remarks, these studies for the record.

To summarize these studies, they demonstrate that short-term intervention and psychotherapeutic counseling not only reduce diagnostic, X-ray, and laboratory studies but also reduce the incidence of hospitalization. Thus, the cost of additional counseling services would be more than offset by the reduction of costs of hospitalization and unnecessary laboratory and X-ray studies. This has been clearly demonstrated in Health Maintenance Organization. The cost savings in the Health Maintenance Organizations concept tend to be the result of reductions in hospital utilization. We wish to point out that psychological services tend to be out-patient based rather than hospital based services. Thus, the diagnostic and counseling services of psychology could serve as a deterrent to overutilization of medical services which are already in short supply and hospital beds of which there is a chronic shortage. Our crises intervention studies show that the prompt effective counseling with people tends to reduce the number of people entering mental hospitals, as well.

We believe that utilization control must occur through peer review mechanisms rather than through the source of referral. The profession of psychology has established its own peer review mechanism which is accepted by the health insurance industry.

For the reasons cited, we ask the HR-1 be amended so that psychologists will be listed as physicians for the purpose of providing diagnostic and treatment services for mental, psychoneurotic and personality disorders as well as for the diagnosis and treatment of mental retardation, vocational rehabilitative services, and child care services.

Thank you very much.

PREPARED STATEMENT OF DR. A. EUGENE SHAPIRO

Mr. Chairman and Members of the Committee: I am grateful for this opportunity to share my thoughts with you on this important issue. I am Dr. A. Eugene Shapiro, a Diplomate in Clinical Psychology and in private practice for close

to twenty years. I am also a Consultant in Psychology to St. Michaels Hospital in Newark, New Jersey, a General Hospital, and I have a Staff Appointment to another General Hospital, the Newark Beth Israel Medical Center.

I have also been involved with the professional affairs of psychology. I have been Chairman of the Insurance Committee of the New Jersey State Psychological Association for approximately five years. For the past three years I served on the Committee on Health Insurance of the American Psychological Association. I am on the Board of Governors of the Council for the Advancement of the Psychological Professions and Sciences and on the Board of Directors of the New Jersey Psychological Association, an organization of one thousand psychologists in our State, and I am Past President of the Essex County Psychological Association in New Jersey. Thus, in addition to my professional activities and my involvement with professional organizations, my primary concern has been to work toward providing health services to all of the citizens of the United States in an equitable, non-discriminatory fashion.

Our basic principle reflects contemporary thinking that health is a "right"—and should be provided to all regardless of age, area of residence, i.e. rural or urban, or ability to pay. The primary determinant should be need for service. We also strongly believe that those in need of health services should have the right to choose from licensed professionals functioning within the scope of their practice. We believe that any legislative limitation which precludes this privilege of free selection is not in the best interests of the patient, prevents innovative approaches to treatment and is often poor economics. My primary interest, of course is in the mental health field. In the context of this hearing, it would be in terms of those eligible for Medicare and Medicaid, although the basic interest goes beyond these groupings. As a psychologist, I of course, will focus on the importance of licensed or certified clinical psychologists independently providing mental health services.

Although many in this room are aware of what psychologists are—their training, where they function, and the restraints and restrictions that are legally and professionally applied to insure ethical and competent behavior—there may be some factors that this Committee is not aware of, and I should like to take this opportunity to acquaint you with this background material.

Psychology is relatively unique among the providers of health services in that the majority of psychologists do not provide direct services to the public. Of the thirty thousand members of the American Psychological Association, only about forty percent view their functioning primarily in the health-related area. The major portion, the sixty percent are involved primarily in scientific research or in the academic field. Of the forty percent who function in the health delivery area, most are employed in institutional settings, that is hospitals, mental hygiene clinics or related institutions, such as prisons, homes for the mentally retarded, or other public health agencies. Only about seven percent of the membership of the American Psychological Association are primarily engaged in the private practice of psychology. However, many psychologists who are employed in clinical or institutional settings do have part time private practices and provide a necessary service to the public supplemental to their primary employment. An interesting note is that approximately eighteen hundred psychologists teach in medical schools.

It is unnecessary to reiterate to this Committee the major mental health problems that confront the poor and aged. Surely if any group were to be singled out for having emotional problems concomitant with conditions often outside their control, the poor and aged fit this category.

Psychologists have the training and credentials and controls to function as independent practitioners to supply this public need. Psychologists are now licensed or certified to function independently as providers of mental health services in forty four states and in the District of Columbia. In fact, this very Congress passed the act to license psychologists for independent practice in Washington, D.C. In the few States in which psychologists do not have statutory regulation, the State Association has set up non-statutory regulations to control the profession.

Psychologists are well trained. All laws that have been passed that regulate the practice of psychologists call for a minimum of a Doctorate from a recognized University, internship in an approved setting and post-doctoral training. We have every evidence to believe that our controls over the profession are sufficient to insure our continued functioning as an independent provider of health benefits. In addition to the regulations imposed by law, the American

Psychological Association has a strong ethical code and each State has its own ethical procedures, usually consistent with that of the parent organization. Furthermore, the American Psychological Association has established ten Regional Review Committees, coinciding with the ten regional areas of H.E.W. where questions involving matters of third parties, psychologists or insurance carriers can be adjudicated. These Insurance Review Committees are consistent with those of other professional organizations such as medicine, dentistry, optometry, etc.

The effectiveness of the control over our profession and the ethical functioning of psychologists is reflected in the fact that while the cost of malpractice insurance for most medical specialties has continued to rise to astronomical heights as the public has sought redress through the Courts—the cost for malpractice insurance for psychologists has continued to decline. At present, a private practicing psychologist can receive professional liability insurance in the amount of \$300,000 to \$900,000 per year for a cost of \$40.00 per year. In fifteen years that psychologists have had malpractice insurance, *there has not been one case that has gone to Court*. Why then have psychologists not been included in Medicare-Medicaid provisions in any meaningful way? Perhaps because at the time of passage of Public Law 89-97 in 1965 the Congress had insufficient knowledge of the scope and function of psychologists. But since that time psychology has been accepted as an independent provider of mental health services by many insurance carriers and many providers of benefits to constituents or employees.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), covering five and one-half to six million lives, about a year and a half ago accepted psychologists as independent providers of mental health benefits. In recent testimony before the Subcommittee on Compensation and Employees Benefits of the Senate Committee on Post Office and Civil Service, Mr. Vernon McKenzie, Special Assistant Secretary of Defense for Health and Environment testified that all comments regarding the utilization of psychologists as providers of mental health services were "laudable". At the same hearing Mr. Malcolm McIntyre, Coordinator, Aetna Life and Casualty, the second largest carrier under the Federal Employees program testified that in the year they have recognized psychologists as independent providers of health benefits to federal employees who come under their plan they have had no problem whatever. Mr. Andrew Ruddock, Director, Bureau of Retirement, Insurance and Occupational Health, United States Civil Service Commission, stated to this Subcommittee that the Civil Service Commission favors the inclusion of psychologists as independent health practitioners in its contracts for health benefits for Federal employees. Major insurance carriers such as Massachusetts Mutual, Occidental Life Insurance Company and the Prudential Life Insurance Company of America have indicated that utilizing licensed and certified psychologists as independent providers of mental health benefits does not increase utilization costs, nor does it significantly add to any actuarial costs.

Although there is no evidence that including psychologists as independent practitioners increases costs or utilization, there is significant evidence that suggests that early intervention in the treatment of mental health disorders reduces overall costs of medical expenses. Studies by Cummings and Follette at Kaiser-Permanente¹ clearly show that early intervention and utilization of psychotherapeutic services tend to reduce overall medical costs. In this connection we wonder how many aged people are seeing physicians for a variety of physical ailments which really reflect their need for someone to talk to, someone to listen to them, someone who will give them interest and concern. How many dollars are spent for purported medical care that might be treated less expensively and more productively as a mental health problem? What price do we pay when a poor deprived youngster who needs care for emotional problems does not receive help and later acts out his problem in an antisocial way? Psychologists of course do not have all the answers—no one does—but we can and should be available to provide the help we can.

Under Title XVIII—Health Insurance for the Aged, page 6 of Public Law 89-97, Section 1801 deals with "Prohibition Against Any Federal Interference" and Section 1802 pertains to "Free Choice By Patient Guaranteed". We believe

¹ Cummings, N. A., and Follette, W. T. Psychiatric Services and medical utilization in a prepaid health plan setting; Part II. *Medical Care*, 1968, 6(1). Follette, W. T., and Cummings, N. A. Psychiatric services and medical utilization in a prepaid health plan setting. *Medical Care*, 1967, 5, 25-35.

strongly in these two statements. We believe that they have inherent in them the great traditions of freedom of choice for individuals with minimal external regulatory control. We ask that the profession of psychology also be guaranteed a prohibition against Federal interference and that patients be given free choice. As stated on page 6 Section 1802 "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him with such services." Licensed or certified psychologists, functioning within the scope of their practice are competent to provide such services and by doing so, will meet a social need, increase the number of qualified providers of mental health benefits and may provide new and innovative approaches to the treatment of psychological conditions of the groups that we are all concerned about.

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Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting

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IN TWO PREVIOUS STUDIES^{5,6} the psychiatric practitioner's contention that emotionally disturbed patients do not seek organic treatment for their complaints following the intervention of psychotherapy have been investigated. Although it has long been recognized that a large number of the physical complaints seen by the physician

are emotionally, rather than organically, determined, the more precise relationship between problems in living and their possible expression through apparent physical symptomatology has been difficult to test experimentally. As noted in the previous study, the GHI Project¹ demonstrated that users of psychiatric services were also significantly frequent users of medical services, but the Project was not able to answer the question of whether there is a reduction in the use of medical services following psychotherapy.

Because the facilities and structure of the Kaiser Foundation Health Plan accord an experimental milieu not available to Avnet, the original pilot project in San Francisco was able to demonstrate a significant reduction in medical utilization between the year prior to psychotherapy, and the two years following its intervention. Certain methodologic problems inherent to the pilot study indicated caution and the need for refinement and replication to avoid arriving at premature conclusions. The lack of a control group of what might be termed psychologically-disturbed high-utilizers who did not receive psychotherapy was a serious omission in the first

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This paper is a report of the first of two investigations seeking to develop and test methods of assessing the effect of psychiatric services on medical utilization in a comprehensive medical program. Part II deals with prospective, rather than retrospective, methodology, and will be reported later.

experiment.[†] Furthermore, an error in the tabulation of inpatient utilization was discovered after the experiment had been concluded.^{††} In addition, the question was raised whether the patients studied might, subsequent to the two years following psychotherapy, revert to previous patterns of somatization or, as a new pattern, merely substitute protracted and costly psychotherapy for previous medical treatment.

The Problem

This study investigated the question of whether there is a change in patients' utilization of outpatient and inpatient medical facilities after psychotherapy, comparing the patients studied to a matched group who did not receive psychotherapy.

Psychotherapy was defined as any contact with the Department of Psychiatry, even if the patient was seen for an initial interview only. The year prior to the initial contact was compared with the five subsequent years in both groups.

The problem can be stated simply: Is the provision of psychiatric services associated with a reduction of medical services utilization (defined as visits to other medical clinics, outpatient laboratory and x-ray procedures, and days of hospitalization)?

Methodology

The setting: The Kaiser Foundation Health Plan in the Northern California Region is

a group-practice prepayment plan offering comprehensive hospital and professional services on a direct service basis. Professional services are provided by the Permanente Medical Group—a partnership of physicians. The Medical Group has a contract to provide comprehensive medical care to the subscribers, of whom there were more than a half million at the time of this study. The composition of the Health Plan subscribers is diverse, encompassing most socio-economic groups. The Permanente Medical Group comprises all major medical specialties; referral from one specialty clinic to another is facilitated by the organizational features of group practice, geographical proximity and use of common medical records. During the years of this study (1959-1964), psychiatry was essentially not covered by the Northern California Health Plan on a prepaid basis, but in some areas of the Northern California region psychiatric services were available to Health Plan Subscribers at reduced rates. During the six years of the study, the psychiatric clinic staff in San Francisco consisted of psychiatrists, clinical psychologists, psychiatric social workers, resident psychiatrists at the third- or fourth-year level, and psychology interns, all full-time. The clinic operates primarily as an outpatient service for adults (age eighteen or older), for the evaluation and treatment of emotional disorders, but it also provides consultation for non-psychiatric physicians and consultation in the general hospital and the emergency room. There is no formal "intake" procedure, the first visit with any staff member being considered potentially therapeutic as well as evaluative and dispositional. Regardless of professional discipline, the person who sees the patient initially becomes that patient's therapist unless there is a reason for transfer to some other staff member, and he continues to see the patient for the dura-

[†] The authors acknowledge their debt to Dr. M. F. Collen for this and other suggestions, and to Mr. Arthur Weissman, Medical Economist, Kaiser Foundation Medical care entities, for his expert consultation.

^{††} At that time days of hospitalization per patient and by year were tabulated from each patient's outpatient medical records. Subsequent investigation has revealed that only about a third of the outpatient charts reviewed contained summaries of hospital admissions, and that tabulation of inpatient utilization must be made directly through the separately-kept inpatient records.

tion of the therapy. An attempt is made to schedule the first interview as soon as possible after the patient calls for an appointment. There is also a "drop-in" or non-appointment service for emergencies so that patients in urgent need of psychiatric help usually can be seen immediately or at least within an hour or two of arrival at the clinic.

One of the unique aspects of this kind of associated health plan and medical group is that it tends to put a premium on health rather than on illness, i.e., it makes preventive medicine economically rewarding, thereby stimulating a constant search for the most effective and specific methods of treatment. The question of how psychiatry fits into comprehensive prepaid medical care is largely unexplored; there are not many settings in which it can be answered. Another feature of group practice in this setting is that all medical records for each patient are retained within the organization.

Subjects: The experimental subjects for this investigation were selected systematically by including every fifth psychiatric patient whose initial interview took place between January 1 and December 31, 1960. Of the 152 patients thus selected, 80 were seen for one interview only, 41 were seen for two to eight interviews (mean of 6.2) and were defined as "brief therapy," and 31 were seen for nine or more interviews (mean of 33.9) and were defined as "long-term therapy."

To provide a control group, the medical records of high medical utilizers who had never presented themselves to the Department of Psychiatry were reviewed until a group was selected which matched the psychotherapy sample in age, sex, socioeconomic status, medical utilization in the year 1959, Health Plan membership including at least the years 1959 through 1962, and criteria of psychological distress.

Thus, each experimental patient was matched with a control patient in the criteria above, but without reference to any other variable. Both samples ranged in age from 24 to 62, with a mean of 38.1. Of these, 52 per cent were women and 63 per cent were blue-collar workers or their dependents. The satisfaction of so many criteria in choosing a matched control group proved to be a tedious and time-consuming procedure.

Review of the medical records of the psychiatric sample disclosed consistent and conceptually useful notations in the year prior to the patients' coming to psychotherapy, which could be considered as *criteria of psychological distress*. These consisted of recordings, made by the physicians on the dates of the patients' visits, which were indicative of those patients' emotional distress, whether or not the physicians recognized this when they made the notations. These (38) criteria were assigned weights from one to three in accordance with the frequency of their appearance in medical records and in accordance with clinical experience about the significance of the criteria when encountered in psychotherapeutic practice. The criteria, with weights assigned, are presented in Table 1. In comparing the charts of the psychiatric patients with those of Health Plan patients randomly drawn, it was determined that although some criteria were occasionally present in the medical records of the latter, a weighted score of three within one year clearly differentiated the psychiatric from the non-psychiatric groups. Accordingly, therefore, in matching the control (non-psychotherapy) group to the experimental (psychotherapy) group, the patients selected had records which indicated scores of three or more points for the year 1959. The mean weights of the three experimental groups and the control group in terms of the 38 criteria of psychological

TABLE 1. *Criteria of Psychological Distress with Assigned Weights*

One point	Two points	Three points
1. Tranquilizer or sedative requested.	23. Fear of cancer, brain tumor, venereal disease, heart disease, leukemia, diabetes, etc.	34. Unsubstantiated complaint there is something wrong with genitals.
2. Doctor's statement pt. is tense, chronically tired, was reassured, etc.	*24. Health Questionnaire: yes on 3 or more psych. questions.	35. Psychiatric referral made or requested.
3. Patient's statement as in no. 2.	25. Two or more accidents (bone fractures, etc.) within 1 yr. Pt. may be alcoholic.	36. Suicidal attempt, threat, or preoccupation.
4. Lump in throat.	26. Alcoholism or its complications: delirium tremens, peripheral neuropathy, cirrhosis.	37. Fear of homosexuals or of homosexuality.
*5. Health Questionnaire: yes on 1 or 2 psych. questions.	27. Spouse is angry at doctor and demands different treatment for patient.	38. Non-organic delusions and/or hallucinations; paranoid ideation; psychotic thinking or psychotic behavior.
6. Alopecia areata.	28. Seen by hypnotist or seeks referral to hypnotist.	
7. Vague, unsubstantiated pain.	29. Requests surgery which is refused.	
8. Tranquilizer or sedative given.	30. Vasectomy: requested or performed.	
9. Vitamin B ₁₂ shots (except for pernicious anemia).	31. Hyperventilation syndrome.	
10. Negative EEG.	32. Repetitive movements noted by doctor: tics, grimaces, mannerisms, torticollis, hysterical seizures.	
11. Migraine or psychogenic headache.	33. Weight-lifting and/or health faddism.	
12. More than 4 upper respiratory infections per year.		
13. Menstrual or premenstrual tension; menopausal sx.		
14. Consults doctor about difficulty in child rearing.		
15. Chronic allergic state.		
16. Compulsive eating (or over-eating).		
17. Chronic gastrointestinal upset; aerophagia.		
18. Chronic skin disease.		
19. Anal pruritus.		
20. Excessive scratching.		
21. Use of emergency room: 2 or more per year.		
22. Brings written list of symptoms or complaints to doctor.		

* Refers to the last 4 questions (relating to emotional distress) on a Modified Cornell Medical Index—a general medical questionnaire given to patients undergoing the Multiphasic Health Check in the years concerned (1959-62).

TABLE 2. *Scores for Criteria of Psychological Distress, for the Experimental Groups and the Control Group during the Year Prior to Psychotherapy (1959)*

Group	Total score	No. of patients	Average score
One session only	264	80	3.30
Brief therapy	134	41	3.27
Long-term therapy	246	31	7.94
All experimental (psychotherapy) groups	644	152	4.24
Control (non-psychotherapy) group	629	152	4.13

distress are presented in Table 2: note that there was no significant difference between this dimension of the two groups in 1959.

In order to facilitate comparison of the experimental (psychotherapy) and control (non-psychotherapy) groups, one last criterion for inclusion in the matched group was employed. Each subject in the control group had to be a Health Plan member for the first three consecutive years under investigation inasmuch as the experimental group, though demonstrating attrition in

TABLE 3. *Utilization of Outpatient Medical Services (Excluding Psychiatry) by Psychotherapy Groups for the Year Before (1-B) and the Five Years After (1-A, 2-A, 3-A, 4-A, 5-A) the Initial Interview, and the Corresponding Years for the Non-psychiatric Group*

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only, unit score	911	815	612	372	321	217
No. of pts.	80	80	80	57	53	49
Average	11.4	10.2	7.7	6.5	6.1	4.4
Brief therapy, unit score	778	471	354	202	215	155
No. of pts.	41	41	41	32	30	27
Average	19.0	11.5	8.6	6.3	7.2	5.7
Long-term therapy, unit score	359	323	279	236	151	108
No. of pts.	31	31	31	27	24	19
Average	11.6	10.4	9.0	8.7	6.5	5.7
All experimental (psychotherapy) groups, unit score	2048	1609	1245	810	687	480
No. of pts.	152	152	152	116	107	95
Average	13.5	10.6	8.2	6.4	6.4	5.1
Control (non-psychotherapy) group, unit score	1726	1743	1718	1577	1611	1264
No. of pts.	152	152	152	127	111	98
Average	11.4	11.5	11.3	12.4	14.5	12.9

continued membership after that time, remained intact for those years.

Dependent variable: Each psychiatric patient's utilization of health facilities was investigated first for the full year preceding the day of his initial interview, then for each of the succeeding five years beginning with the day after his initial interview.

The corresponding years were investigated for the control group which, of course, was not seen in the Department of Psychiatry. This investigation consisted of a straightforward tabulation of each contact with any outpatient facility, each laboratory report and x-ray report.* In addition a tabulation of number of days of hospitalization was made without regard to the type or quantity of service provided. Each patient's utilization scores consisted of the total number of separate outpatient and inpatient tabulations.

* These procedures were counted as one even if there were more than one laboratory or x-ray procedure per report in the chart.

Results

The results of this study are summarized in Table 3, which shows the differences by group in utilization of outpatient medical facilities in the year before and the five years after the initial interview for the psychiatric sample, and the utilization of outpatient medical services for the corresponding six years for the non-psychotherapy sample.

The data of Table 3 are summarized as percentages in Table 4, which indicates a decline in outpatient medical (not including psychiatric) utilization for all three psychotherapy groups for the years following the initial interview, while there is a tendency for the non-psychotherapy patients to increase medical utilization during the corresponding years. Applying t-tests of the significance of the standard error of the difference between the means of the "year before" and the means of each of the five "years after" (as compared to the year before), the following results obtain. The declines in outpatient (non-psychiatric) utilization for the "one ses-

TABLE 4. *Comparison of the Year Prior to the Initial Interview with each Succeeding Year, Indicating Per Cent Decline or Per Cent Increase (Latter Shown in Parentheses) in Outpatient Medical (Non-psychiatric) Utilization by Psychotherapy Grouping, and Corresponding Comparisons for the Control Group, with Levels of Significance*

Group	1-A		2-A		3-A		4-A		5-A	
	% change	Signif.	% change	Signif.	% change	Signif.	% change	Signif.	% change	Signif.
One session only	10.5	NS	32.8	.05	44.75	.05	46.5	.05	61.4	.01
Brief therapy	39.5	.05	53.2	.05	66.8	.01	62.1	.01	70.0	.01
Long-term therapy	10.0	NS	22.3	.05	25.0	.05	43.0	.05	50.9	.05
All experimental (psychotherapy) groups	21.4	.05	39.2	.01	48.2	.01	52.3	.01	62.5	.01
Control (non-psychotherapy) group	None	—	None	—	(8.8)	NS	(27.2)	.05	(13.2)	NS

sion only" and the "long-term therapy" groups are not significant for the first year following the initial interview while the declines are significant at either the .05 or .01 levels for the remaining four years. In the "brief therapy" group, there are statistically significant declines in all five of the years following the initial interview. As further indicated in Table 4, there is a tendency for the control group to *increase* its utilization of medical services, but this proved significant for the "fourth year after" only.

The question was raised as to whether the patients demonstrating declines in medical utilization have done so because they have merely substituted protracted psychotherapy visits for their previous medical visits.

As shown in Table 5, the number of patients in the one-session-only group who

return in the third to fifth years for additional visits is negligible. Comparable results are seen in the brief-therapy group. In contrast, the long-term-therapy group reduces its psychiatric utilization by more than half in the "second year after," but maintains this level in the succeeding three years. By adding the outpatient medical visits to the psychiatric visits, it becomes clear that whereas the first two psychotherapy groups have not substituted psychotherapy for medical visits, this does seem to be the case in the long-term psychotherapy group. These results are shown in Table 6, and indicate that the *combined* outpatient utilization remains about the same from the "year before" to the "fifth year after" for the third psychotherapy group, while declines are evident for the first two psychotherapy groups. As regards the combined (medical

TABLE 5. *Average Number of Psychotherapy Sessions per Year for Five Years by Experimental Group*

Group	1-A	2-A	3-A	4-A	5-A
One session only	1.00	0.00	0.00	0.02	0.06
Brief therapy	6.22	0.00	0.09	0.57	0.52
Long-term therapy	12.33	5.08	5.56	5.88	5.05

TABLE 6. *Combined Averages (Outpatient Medical plus Psychotherapy Visits) of Utilization by Years Before and After Psychotherapy for the Experimental Groups, and Total Outpatient Utilization by Corresponding Years for the Control (Non-psychiatric) Group*

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only	11.4	11.2	7.7	6.5	6.1	4.5
Brief therapy	19.0	17.7	8.6	6.4	7.7	6.2
Long-term therapy	11.6	22.7	14.1	14.3	12.4	10.8
All experimental (psychotherapy) groups	13.5	15.3	9.2	8.3	7.9	6.2
Control group	11.4	11.5	11.3	12.4	14.5	12.9

plus psychiatric) utilization, the long-term psychotherapy group is not appreciably different from the control (non-psychiatric) group.

Investigation of inpatient utilization reveals a steady decline in utilization in the three psychotherapy groups from the "year before" to the "second year after," with the three remaining "years after" maintaining the level of utilization attained in the "second year after." In contrast, the control sample demonstrated a constant level in number of hospital days throughout the six years studied. These results are shown in Table 7, which indicates that

the approximately 60 per cent decline in number of days of hospitalization between the "year before" and the "second year after" for the first two psychotherapy groups is maintained to the "fifth year after"; this decline is significant at the .01 level. The inpatient utilization for the "long-term therapy" group in the "year before" was over twice that of the non-psychiatric sample, and about three times that of the first two psychotherapy groups. The significant (.01 level) decline of 88 per cent from the "year before" to the "second year after" is maintained through the "fifth year after," rendering the inpa-

TABLE 7. *Number of Days of Hospitalization and Averages by Psychotherapy Group for the Year Before and the Five Years After Psychotherapy, and the Corresponding Period for the Non-psychotherapy Group* (Note: Health Plan average is .8 per year for patients 20 years old or older.)

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only, days/year	117	78	52	32	33	31
No. of pts.	80	80	80	57	53	49
Average	1.46	0.98	0.65	0.56	0.62	0.63
Brief therapy, days/year	66	44	31	24	23	23
No. of pts.	41	41	41	32	30	27
Average	1.61	1.07	0.76	0.75	0.77	0.85
Long-term therapy, days/year	153	37	19	18	16	13
No. of pts.	31	31	31	27	24	19
Average	4.94	1.09	0.61	0.67	0.67	0.68
All experimental (psychotherapy) groups, days/year	336	159	102	74	72	67
No. of pts.	152	152	152	116	107	95
Average	2.21	1.05	0.68	0.64	0.67	0.71
Significance		.05	.02	.05	.05	.05
Control (non-psychotherapy) group, days/year	324	307	477	255	208	197
No. of pts.	152	152	152	127	111	98
Average	2.13	2.02	3.07	2.02	1.87	2.01
Significance		NS	.05	NS	NS	NS

tient utilization of the third psychotherapy group comparable to that of the first two psychotherapy groups.

In terms of decline in use of inpatient services (days of hospitalization), however, the long-term psychotherapy group and the control group are different, in that the former patients significantly reduce their inpatient utilization from the "year before" to the "fifth year after." However, the small size of the samples limits the conclusions that can be drawn.

Discussion

The original pilot study of which this project is an outgrowth was proposed by the senior author as an aid in planning for psychiatric care as part of comprehensive prepaid health-plan coverage. It had long been observed that some of this psychiatric clinic's patients, as well as many patients in the hospital for whom a psychiatric consultation was requested, had very thick medical charts. It was also repeatedly noted that when these patients were treated from a psychiatric point of reference, i.e., as a person who might have primarily emotional distress which was expressed in physical symptoms, they often abandoned their physical complaints. It seemed reasonable to expect that for many of these people, psychiatrically-oriented help was a more specific and relevant kind of treatment than the usual medical treatments.

This would be especially true if the effects of psychiatric help were relatively long-lasting, or if a change in the patient affected others in his immediate environment. In the long run, the interruption of the transmission of sick ways of living to succeeding generations would be the most fundamental and efficient kind of preventive medicine. It therefore seemed imperative to test the intuitive impressions that this kind of patient could be treated more effectively by an unstructured psychiatric

interview technique than by the more traditional medical routine with its directed history.

The Balints^{2,3} have published many valuable case reports which describe the change in quantity and quality in patients' appeals to the general practitioner after the latter learns to listen and understand his patients as people in distress because of current and past life experiences. It would be difficult, however, to design a statistical study of those patients and of a matched control group treated for similar complaints in a more conventional manner.

Psychiatry has been in an ambivalent position in relation to the rest of medicine: welcomed by some, resented by others, often, however, with considerable politeness which serves to cover up deep-seated fears of and prejudices against "something different." In a medical group associated with a prepaid health plan, conditions are favorable for integrating psychiatry into the medical fraternity as a welcomed and familiar (therefore unthreatening) member specialty. The inherent ease of referral and communication within such a setting would be much further enhanced by the factor of prepayment, which eliminates the financial barrier for all those who can afford health insurance. For many reasons, then, this setting provides both the impetus and the opportunity to attempt an integration of psychiatry into general medical practice and to observe the outcome. In the past two decades, medicine has been changing in many significant ways, among which are prepaid health insurance, group practice, increasing specialization, automation, and a focus on the "whole person" rather than on the "pathology."

Forsham⁷ and others have suggested that at some not-too-distant date the patient will go through a highly automated process of history, laboratory procedures and phys-

ical tests, with the doctor at the end of the line doing a physical examination but occupying mainly the position of a medical psychologist. He will have all the results of the previously completed examinations which he will interpret for the patient, and he will have time for listening to the patient, if he wishes to do so. The "Multiphasic Health Check,"⁴ which has been used for many years in the Northern California Region in the Kaiser Foundation Medical Clinics and which is constantly being expanded, is just such an automated health survey, and Medical Group doctors are in the process of becoming continually better psychologists. Eventually many more of the patients who are now seen in the psychiatric clinic will be expertly treated in the general medical clinics by more "complete physicians."

A study such as this raises more questions than it provides answers. One question alluded to above is whether, with an ongoing training program such as Balint has conducted for general practitioners at Tavistock Clinic, internists might not be just as effective as psychiatric personnel in helping a greater percentage of their patients. A training seminar such as this has been conducted by Dr. Edna Fitch in the department of Pediatrics of Permanente Medical Group in San Francisco for many years and has been effective in helping pediatricians to treat, with more insight and comfort, emotional problems of children and their families and physical disorders which are an expression of emotional distress.

Using a broader perspective than the focus on the clinical pathology, one can wonder what social, economic or cultural factors are related to choice of symptoms, attitudes toward being "sick" (mentally or physically), attitudes toward and expectations of the doctor, traditions of family illness, superstitions relating to

bodily damage, child raising practices, etc. How often is the understanding of such factors of crucial importance for effective and efficient treatment for the patient? Of special interest in general medical practice and overlooked almost routinely by physicians (and by many in the psychological field) are the "anniversary reactions" in which symptoms appear at an age at which a relative had similar symptoms and/or died.

Health Plan statistics indicate an increase in medical utilization with increasing age in adults. This is consistent with the relatively flat curve seen in the "medical utilization" of the control sample over the six year period and is in marked contrast to that of the experimental sample. There is the implication in this that some of the increasing symptoms and disability of advancing years are psychogenic and that psychotherapeutic intervention may in some cases function as preventive medical care for the problems associated with aging as well as preventive medicine in children.

A certain percentage of the long-term psychotherapy group seems to continue without diminution of number of visits to the psychiatric clinic; these patients appear from the data to be interminable or life-long psychiatric utilizers just as they had been consistently high utilizers of non-psychiatric medical care before. They seem merely to substitute psychiatric visits for some of their medical clinic visits. A further breakdown of the long-term group into three parts, e.g., less than 50, 50 to 150, and more than 150 visits, would probably help to sort this population's utilization into several patterns. More precise data on these groups would suggest modifications in classifications and methods of therapy or might suggest alternatives to either traditional medical or traditional psychiatric treatment in favor of some at-

tempt to promote beneficial social changes in the environments of these chronically disturbed people.

Sources of Criticism

(1) One problem in providing a control group comparable to an experimental group in this kind of study is that, although undoubtedly having emotional distress, and in a similar "quantity" according to our yardstick, the control group did *not* get to the psychiatric clinic by either self- or physician referral. The fact that the control patients had not sought psychiatric help may reflect a more profound difference between this group and the experimental group than is superficially apparent. One cannot assume that the medical utilization of this control group would change if they were seen in the Psychiatry Clinic. (This objection will be minimized in the "prospective" part of this study, which will be reported in another paper). Although the average inpatient utilization for the three combined psychotherapy groups is the same as that of the control group in the year before (1959), the inpatient utilization of the long-term psychotherapy group is two and a half times that of the control group. If the study were extended to several years before, rather than just one year, it would become evident whether this was just a year of crisis for the long-term group or whether this had been a longer pattern of high inpatient utilization.

(2) Patients who visit the psychiatric clinic may, for one reason or another, seek medical help from a physician not associated with the Medical Group so that his medical utilization is not recorded in the clinic record, the source of information about utilization. In the long-term-therapy group the therapist is usually aware if his patient is visiting an outside physician, and although it is an almost negligible factor in that group, there can be no information in this regard for the one-session-only and brief-therapy groups without follow-up investigation.

(3) There is no justification in assuming that decreased utilization means better medical care, necessarily. Criteria of

improvement would have to be developed and applied to a significantly large sample to try to answer this important question.

(4) Patients may substitute for physical or emotional symptoms behavioral disturbances which do not bring them to a doctor but may be just as distressing to them or to other people.

(5) The "unit" of utilization cannot be used as a guide in estimating costs, standing as it does for such diverse items. In itself the units are not an exact indicator of severity of illness nor of costs. A person with a minor problem may visit the clinic many times, while a much more severely ill person may visit the clinic infrequently. Even more striking is the variation in the cost of a unit, varying from about a dollar for certain laboratory procedures to well over a hundred dollars for certain hospital days (with admissions procedures, laboratory tests, x-rays, consultations, etc.) each worth one "unit." To arrive at an approximation of costs, the units have to be retabulated in cost-weighted form.

Suggested Further Studies

(1) The question of treatment of patients by non-medical professional clinicians has been argued for more than a half century. It is generally recognized that there are not enough psychiatrists now and that there will not be enough in the foreseeable future to treat all those persons who have disabling emotional disorders. In the late President Kennedy's program for Mental Health this lack was recognized; the recommendation for professional staff for community Mental Health Centers included clinical psychologists, psychiatric social workers and other trained personnel. Having little distinction in our psychiatric clinic between the various disciplines as far as their functions are concerned, it would be feasible and interesting to compare therapeutic results of the disciplines as well as individuals with various types of patients and various types of psychotherapy.

(2) Is length of treatment correlated with diagnostic category, original prog-

nosis by therapist, socio-economic level of patient, discipline and orientation of therapist, or "severity of pathology"?

(3) What happens to the spouse, parents, and children of the patients who are seen in psychiatry?

(4) Are there distinguishing patterns of complaints in the three psychotherapy groups?

(5) How do blue-collar patients differ from white-collar or professional patients in number of interviews, diagnostic label, use of medication, recommendation of hospitalization, and type of complaints?

(6) What is the nature of the illness that resulted in hospitalization before the patient came to psychiatry—and after? How often was this a diagnostic work-up because the internist could not find "anything wrong" in the clinic?

Summary

The outpatient and inpatient medical utilization for the year prior to the initial interview in the Department of Psychiatry as well as for the five years following were studied for three groups of psychotherapy patients (one interview only, brief therapy with a mean of 6.2 interviews, and long-term therapy with a mean of 33.9 interviews) and a control group of matched patients demonstrating similar criteria of distress but not, in the six years under study, seen in psychotherapy. The three psychotherapy groups as well as the control (non-psychotherapy) group were high utilizers of medical facilities, with an average utilization significantly higher than that of the Health Plan average. Results of the study indicated significant declines in medical utilization in the psychotherapy groups when compared to the control group, whose inpatient and outpatient utilization remained relatively constant throughout the six years. The most significant declines occurred in the second year after the initial interview, and the one-

interview-only and brief-therapy groups did not require additional psychotherapy to maintain the lower utilization level for five years. On the other hand, after two years the long-term-psychotherapy group attained a level of psychiatric utilization which remained constant through the remaining three years of study.

The combined psychiatric and medical utilization of the long-term-therapy group indicated that for this small group there was no over-all decline in outpatient utilization inasmuch as psychotherapy visits seemed to supplant medical visits. On the other hand, there was a significant decline in inpatient utilization, especially in the long-term-therapy group from an initial utilization of several times that of the Health Plan average, to a level comparable to that of the general adult Health Plan population. This decline in hospitalization rate tended to occur within the first year after the initial interview and remained generally comparable to the Health Plan average for the five years.

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Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting:

Part II

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DOES PSYCHOTHERAPY ALTER the pattern of medical care? Can emotionally distressed patients who might benefit from psychotherapy be identified by screening a group of patients taking a health checkup? Will an automated psychological test be useful in such a screening process? These are the questions we set out to answer in this study.

The first question has been studied and the results reported by the authors.⁷ It was

found that psychotherapy patients initially were high "utilizers," but that after psychotherapy their utilization declined significantly. On the other hand, the utilization of the matched "control" group (not receiving psychotherapy) did not decline. The brief therapy and one-session-only psychotherapy groups had the largest decline in outpatient utilization, which theoretically helped to offset the cost of providing the psychotherapy. The decline in outpatient utilization of the long-term psychotherapy group was not enough to offset the cost of psychiatric and non-psychiatric treatment, being greater than the cost of prior medical utilization alone. However, this group showed considerable decline in days of hospitalization, which helped to make their psychiatric care financially less costly in this setting.

A major criticism of Part I⁷ was that, although the psychotherapy and "control" groups were matched socioeconomically and demographically, in medical utilization and in degree of emotional distress, the groups remained different in one crucial respect: the psychotherapy sample, whether self- or physician-referred, voluntarily presented themselves to the psychiatric clinic. In contrast, the matched group did not come to the psychiatric clinic even if re-

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This paper is Part II of a two-part series seeking to develop and test methods of assessing the effects of psychiatric services in a comprehensive medical program. Part I involved retrospective methodology, while the present paper reports a prospective study.

TABLE 1. *Criteria of Psychological Distress with Assigned Weights*

One point	Two points	Three points
1. Tranquilizer or sedative requested.	23. Fear of cancer, brain tumor, venereal disease, heart disease, leukemia, diabetes, etc.	34. Unsubstantiated complaint there is something wrong with genitals.
2. Doctor's statement pt. is tense, chronically tired, was reassured, etc.	*24. Health Questionnaire: yes on 3 or more psych. questions.	35. Psychiatric referral made or requested.
3. Patient's statement as in no. 2.	25. Two or more accidents. (bone fractures, etc) within 1 yr. Pt. may be alcoholic.	36. Suicidal attempt, threat, or preoccupation.
4. Lump in throat.	26. Alcoholism or its complications: delirium tremens, peripheral neuropathy, cirrhosis.	37. Fear of homosexuals or of homosexuality.
*5. Health Questionnaire: yes on 1 or 2 psych. questions.	27. Spouse is angry at doctor and demands different treatment for patient.	38. Non-organic delusions and/or hallucinations; paranoid ideation; psychotic thinking or psychotic behavior.
6. Alopecia areata.	28. Seen by hypnotist or seeks referral to hypnotist.	
7. Vague, unsubstantiated pain.	29. Requests surgery which is refused.	
8. Tranquilizer or sedative given.	30. Vasectomy: requested or performed.	
9. Vitamin B ₁₂ shots (except for pernicious anemia).	31. Hyperventilation syndrome.	
10. Negative EEG.	32. Repetitive movements noted by doctor: tics, grimaces, mannerisms, torticollis, hysterical seizures.	
11. Migraine or psychogenic headache.	33. Weight-lifting and/or health faddism.	
12. More than 4 upper respiratory infections per year.		
13. Menstrual or premenstrual tension; menopausal sx.		
14. Consults doctor about difficulty in child rearing.		
15. Chronic allergic state.		
16. Compulsive eating (or over-eating).		
17. Chronic gastrointestinal upset; aerophagia.		
18. Chronic skin disease.		
19. Anal pruritus.		
20. Excessive scratching.		
21. Use of emergency room: 2 or more per year.		
22. Brings written list of symptoms or complaints to doctor.		

* Refers to the last 4 questions (relating to emotional distress) on a Modified Cornell Medical Index—a general medical questionnaire given to patients undergoing the Multiphasic Health Check in the years concerned (1959-62).

ferred by their physicians. The nature of the difference between the two groups made conclusions tentative. The question is crucial, because it may be that the group which did not come to the psychiatric clinic is *unable* to make use of psychiatric services in a meaningful manner, and that psychotherapy would not decrease the medical utilization of this group. The most obvious way to provide a valid control group would be to choose a large sample by uniform criteria and randomly divide it into two parts, then treat the two parts differently and observe the results. The present paper is a report on such a prospective study.

Method

The setting: The Kaiser Foundation Health Plan of Northern California is a group-practice prepayment plan offering comprehensive hospital and professional services on a direct-service basis. Professional services are provided by the Permanente Medical Group—a partnership of physicians. The Medical Group has a contract to provide comprehensive medical care to the members of the Plan, of whom there were three-quarters of a million at the time of this study. The composition of the Health Plan membership is diverse,

encompassing most socioeconomic groups. The Permanente Medical Group comprises all major medical specialties; referral from one specialty clinic to another is facilitated by the organizational features of group practice, geographical proximity and the use of common medical records. During the years of this study (1965-1966), only 17 per cent of Health Plan members were eligible for psychiatric benefits on a prepaid basis, but in most areas of the Northern California region psychiatric services were available to Health Plan Subscribers at reduced rates. The psychiatric staff in the San Francisco Clinic, where the present study took place, consists of psychiatrists, clinical psychologists, psychiatric social workers, and psychology and social work interns. The clinic operates primarily as an outpatient service for adults and children for the evaluation and treatment of emotional disorders, but it also provides consultation for non-psychiatric physicians and consultation in the general hospital and the emergency room. There is no formal "intake" procedure, the first visit with any staff member being considered potentially therapeutic as well as evaluative and dispositional. Regardless of professional discipline, the person who sees the patient initially becomes that patient's therapist unless there is reason for transfer to some other staff member, and he continues to see the patient for the duration of the therapy. An attempt is made to schedule the first interview as soon as possible after the patient calls for an appointment. There is also a "drop-in" or non-appointment service for emergencies so that patients in urgent need of psychiatric help usually can be seen immediately or at least within an hour or two after arrival at the clinic.

One of the unique aspects of this kind of associated health plan and medical group is that it tends to put a premium on health rather than on illness, i.e., it makes pre-

ventive medicine economically rewarding, thereby stimulating a constant search for the most effective and specific methods of treatment. Another feature of group practice in this setting is that all medical records for each patient are maintained within the organization.

The subjects: The source of the population for this study was 10,667 patients who voluntarily presented themselves in a six-month period to the San Francisco Kaiser-Permanente Automated Multiphasic Clinic for a health check, part of which includes 19 computerized procedures, ranging from simple body measurements to complex laboratory tests.² A routine part of the three-hour series of examinations is the administration of a psychological test known as the Neuro-Mental Questionnaire, or NMQ.⁴ This consists of 155 dichotomous questions which (eventually, when the test is fully developed) will identify approximately 60 psychological categories. Each question is printed on a separate pre-punched card, which the patient must deposit in either the "true" or the "false" section of a divided box. For this study only the six major psychological categories were used: depression, hysteria, obsessional, panic and anxiety attacks, passive-aggressive, and schizophrenia. (This probably would identify most of the patients who could be identified by the full test, because 87 per cent of the patients seen in the Department of Psychiatry fall into one or more of these six categories.)

The NMQ was computer-scored, and results were sent to the investigators within 24 hours of the time the patient had the questionnaire. The medical charts of the patients identified by the test were reviewed for evidences of psychological distress in the 12-month period prior to the Multiphasic examination.

"Criteria of psychological distress" (developed in Part I¹ and presented in Table 1) refer to physicians' notes in the patients'

TABLE 2. *Psychological, Socioeconomic and Demographic Characteristics of 822-patient Sample with Positive NMQ and Plus-3 or More on Criteria of Distress*

NMQ categories (with category number)	Blue collar			White collar			Totals
	Urban	Suburban	Rural	Urban	Suburban	Rural	
Neurotic							352 (42.8 per cent)
Depressive	30	37	11	2	43	2	1 96
Hysteric	16	12	5	1	2	4	2 26
Obsessional	25	23	6		35	6	70
Obs. hysteric	16, 25	10	3	2	12	3	30
Panic/anxiety	22	25	11		13	7	1 57
Phobic	24	28	9	2	19	15	73
Character disorders							261 (31.8 per cent)
Anal char.	13, 25	4	2		3	2	11
Depressive	25, 30 (13)	26	7	2	18	3	56
Hysterical	13, 16	15	8	1	14	2	1 41
Phobic	16, 24	21	12	1	20	7	1 62
Passive/aggr.	13	27	5	1	25	13	71
Sado-masoch.	13, 16, 30	6	3	1	8	2	20
Psychotic							209 (25.4 per cent)
Schizophrenic	37	55	19	3	44	20	1 142
Pseudo-neur.	37, 25, 30	21	8	2	24	11	1 67
Schiz.	(plus 1 more)						
TOTALS	310	109	18	280	97	8	

Mean age: 45.1 yrs.
 No. women: 70.1 %
 Blue collar: 53.2 %
 Urban: 71.8 %
 Suburban: 25.0 %
 Rural: 3.2 %
 Neurotic: 42.8 %
 Char. dis.: 31.8 %
 Psychotic: 25.4 %

medical charts which indicated emotional distress, whether or not the physicians recognized them as such. These 38 criteria have assigned weights from one to three, a weighted score of three within one year being accepted as an indication that a patient is in psychological distress. Accordingly, patients for the present study had 1) a "positive NMQ," and 2) a score of three or more points in "Criteria of Psychological Distress," for the 12 months prior to taking the Multiphasic examination.

Of the 10,667 patients who took the NMQ, 3,682, or 36.4 per cent, yielded a positive score in one or more of the six NMQ categories (depression, hysteria, obsessional, panic-anxiety, passive-aggressive, schizophrenic). Of this group, 822 (7.7 per cent) also scored three points or more in "criteria of distress." Of the 6,985 patients who did not score positively on the NMQ, only 56 (0.8 per cent) scored three or more points on the "Criteria of Distress." Thus the use of scales in only six categories of the NMQ proved to be a useful method of eliminating two-thirds of the Multiphasic

population in our search for a group of experimental subjects.

The psychological, socioeconomic and demographic characteristics of the 822-patient sample are given in Table 2. It will be noted that the mean age of 45.1 years is higher than the mean age of 38.1 years for patients generally seen in the Department of Psychiatry. Because the NMQ was administered to only the first 100 patients taking the Multiphasic examination each day, rather than the full 130, appreciably more women were tested than men, because the men tend to make evening appointments. Consequently, 71.0 per cent of the sample is composed of women. It will be noted further that in the 822-patient sample 43 per cent were categorized as neurotic, 32 per cent as having character disorders and 25 per cent as psychotic. There was no difference between the percentages of blue-collar patients and white-collar patients diagnosed "psychotic."

Experimental condition: All patients with both positive NMQ's and three or more "distress" points were alternately assigned

to either the referred or non-referred ("control") groups. For the referred patients the computer printed out the following "consider-rule": *Consider referral to psychiatry for emotional problems.* The 411 patients assigned to the control group did not, of course, have such a consider-rule on their print-outs.

The physician participants: A few weeks after the Multiphasic screening, every patient has a routine follow-up office visit with one of 32 internists. At this time the physician interviews the patient, completes the physical examination, reviews the clinical information from all sources, and provides appropriate treatment or referral. Prior to conducting the present experiment, the physician co-author of this paper met with the internists, explained the nature of the study and solicited their individual cooperation. They were informed that they would be seeing patients whose Multiphasic print-outs would contain the consider-rule suggesting referral to psychiatry. This was to be regarded as one more item of information to the physician, who would weigh it along with his total knowledge of the patient and make the ultimate decision whether to make such a referral. The internists also were advised that other patients would comprise the control group of the study, would not have the consider-rule in their print-outs, and would be undistinguishable from the other Multiphasic patients they would see routinely on follow-up visits.

Thus, "referred" patients (consider-rule) might or might not be referred to psychiatry, and, if referred, might or might not choose to come; or, if not referred by the internist, they might come to the psychiatric clinic through other channels. On the other hand, control patients (no consider-rule) might be referred to psychiatry as the result of the routine practice of medicine in this setting and without regard to the ex-

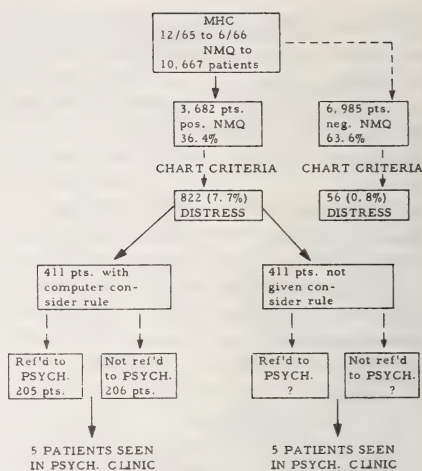


FIG. 1.

periment, and, again, might choose to come or not to come to the psychiatric clinic. The various possibilities are shown in Figure 1.

Results

No Experimental Generation of a Psychiatric Population

Six months after the last experimental subject consulted with his internist on his Multiphasic follow-up visit, only five of the 411 patients given the consider-rule had made and kept appointments in the psychiatric clinic! This figure is exactly the same as the number of patients from the control group who made and kept appointments in the psychiatric clinic. Thus, the experimental conditions failed to generate a psychiatric population, and were in no way superior in obtaining early referral to psychiatry than the usual, routine medical practice in this setting. (See Fig. 1.)

Within the referred group there were found to be 40 patients who had previously been seen in the psychiatric clinic, and in

the control group there were 42. None of the 82 patients previously seen in psychotherapy returned during the course of the experiment.

Usefulness of Automated Screening

The NMQ, as part of an automated multiphasic screening, proved to be a useful instrument in identifying a population within which the patients in emotional distress would be found. As seen in Figure 1, 36.4 per cent of the patients with positive NMQ's also were in emotional distress, while less than one per cent of the patients who did not have positive NMQ's were found to be in emotional distress.

Degree of Internists' Participation

At the conclusion of the primary phase of this study, and after the last patient had undergone his follow-up visit, 30 of the 32 participating internists were interviewed individually to determine their reactions to the computerized procedure and why they did or did not refer to psychiatry. As noted in Figure 1, about half the patients given the consider-rule in their computer printouts actually were referred to psychiatry by their internists according to notations to that effect in the patients' charts.

a. Ten (33 per cent) of the internists did not even recall seeing a consider-rule for referral to psychiatry; 20 (67 per cent) stated they saw instances of such a consider-rule, but the number seen varied from one to 15.

b. Of the 20 internists who saw the consider-rule, eight made no referrals, four referred all such patients, and eight referred half or more.

c. Reasons given for reluctance to refer centered mostly about the physician's feelings regarding having to deal with an emotional problem when his time with the patient was limited. He felt he would open a "Pandora's box" that could not appropriately be handled

in the fifteen minutes allotted for the initial return visit. The second most often-mentioned reason for not referring was the physician's knowledge of the patient and his circumstances. Typical of this was the reply: "I know this patient well. I referred him before and he wouldn't go. I had no reason to believe he would go this time." Or, "I know this patient has emotional problems, but we have been handling them here because she is reluctant to see a psychiatrist." A third type of response by the physician was one of antagonism to the procedure. A few internists complained that it was "cold" or "impersonal."

d. Internists who made referrals remarked that it made their job somewhat easier. They were startled by the accuracy of the consider-rule, for after opening up the issue of emotional problems, they found their patients eager to discuss them. One physician stated he felt more comfortable referring a patient to psychiatry when the patient could blame the computer and not the doctor.

e. Ultimately, the internist's individual procedure regarding referral to psychiatry seemed little affected by the consider-rule. Physicians who routinely and easily refer to psychiatry continued to do so in the experiment, while physicians who usually do not refer to psychiatry essentially ignored the consider-rule. For the most part, it was the individual physician's mode of practice that mattered.

Degree of Outpatient and Inpatient Medical Utilization

Each referred and control patient's utilization of health facilities was investigated for the full year prior to the patient's having taken the Multiphasic screening. This

TABLE 3. *Average Utilization of Outpatient Medical Services for the Year Prior to the Multiphasic Screening for Both Referred and Control Groups by Diagnosis, Socioeconomic Status, and Residence (Excluding Rural)*

	Blue collar		White collar		Totals
	Urban	Suburban	Urban	Suburban	
Neurotic					
No. patients	135	45	124	37	341
Score	2538	886	2505	673	6602
Mean	18.8	19.6	20.2	18.4	19.4
Character disorder					
No. patients	99	37	88	29	253
Score	1168	396	994	336	2894
Mean	11.8	10.7	11.3	11.6	11.4
Psychotic					
No. patients	55	19	44	20	138
Score	677	217	480	234	1608
Mean	12.3	11.4	10.9	11.7	11.6
Pseudo-neurotic					
No. patients	21	8	24	11	64
Score	452	158	571	289	1470
Mean	21.5	19.7	23.8	26.3	22.9

investigation consisted of a straightforward tabulation of each contact with any outpatient facility, each laboratory report and x-ray report. In addition, a tabulation of number of days of hospitalization was made without regard to the type or quantity of service provided. Each patient's utilization scores consisted of the total number of separate outpatient tabulations. These results are summarized in Table 3 (outpatient) and Table 4 (inpatient). The rural patients were excluded, inasmuch as their number was too small to contribute significantly to the results. As expected, no significant differences were found between the experimental and control groups, and both groups are combined (with rural patients excluded) in Tables 3 and 4.

All 796 patients (26 rural patients excluded) were significantly high utilizers of both outpatient and inpatient medical services.

A $2 \times 3 \times 4$ analysis of variance of the 796 patients indicated no significant difference in terms of blue versus white collar, or urban versus suburban conditions, as regards the utilization of both outpatient and inpatient medical services.

There was a significant difference in the degree of utilization of both outpatient and inpatient medical services in terms of diagnostic category. The neurotic patients had the highest outpatient utilization, whereas the psychotic patients had the highest inpatient utilization.

The outpatient utilization of the pseudo-neurotic schizophrenic resembled that of the neurotic, while the inpatient utilization of the pseudoneurotic schizophrenic is not significantly different than that of the psychotic.

Patients with character disorders utilize outpatient services at the same rate as psychotics, but their inpatient rate is approximately half-way between neurotic and psychotic inpatient rates.

Discussion

Research in human behavior is easy to do, but difficult to do well. A research design may look fine on paper, but may not be feasible in fact. Such was the case with the present experiment: no experimental population was generated. This result can be instructive, however, and we will proceed to search for serendipitous results. Human

TABLE 4. *Average Utilization of Inpatient Medical Services (Days of Hospitalization) for the Year Prior to the Multiphasic Screening for Both Referred and Control Groups by Diagnosis, Socioeconomic Status, and Residence, Excluding Rural**

	Blue collar		White collar		Totals
	Urban	Suburban	Urban	Suburban	
Neurotic					
No. patients	135	45	124	37	341
Score	170	60	165	48	443
Mean	1.26	1.34	1.33	1.29	1.30
Character disorder					
No. patients	99	37	88	29	253
Score	285	93	239	84	701
Mean	2.88	2.51	2.72	2.91	2.77
Psychotic					
No. patients	55	19	44	20	138
Score	235	94	200	79	608
Mean	4.27	4.95	4.54	3.95	4.41
Pseudo-neurotic					
No. patients	21	8	24	11	64
Score	105	39	122	58	324
Mean	5.00	4.88	5.08	5.27	5.03

* (Note: Health Plan Average is 0.8 per year for patients 20 years old or older.)

subjects cannot be manipulated for experimental or therapeutic purposes in the same way that animals or machines can. This applies to the doctors in this experiment as well as the patients.

This observation may be timely and relevant now when vast sums of money are being spent in developing mental health programs, many of which are designed on paper from an armchair and have never been proven to be clinically effective.

A recent paper from the University of California at Los Angeles Alcoholism Research Clinic⁵ found the results to be the same in a group of alcoholics randomly assigned by court probation to one of three treatment conditions: (1) a psychiatrically-oriented outpatient alcoholic clinic, (2) Alcoholics Anonymous, (3) no treatment. One might conclude that the answer to the problem of alcoholism *may not* be the provision of a multitude of "alcoholic clinics" across the country. Similarly, it has never been demonstrated that a "suicide prevention center" has lowered the incidence of suicide in any community. We might, on the other hand, expect that such a center would be likely to increase (1) preoccupation with

suicide in the community, (2) the number of suicidal threats, and (3) the number of suicidal gestures. In other words, if people volunteer to play dramatic life-saver, we can confidently expect others to volunteer to threaten self-destruction. Nevertheless, we have suicide prevention centers popping up all over the land.

The question is to what extent psychiatric patients can be "found" in the community and then successfully treated. Is it possible and worthwhile to induce an ever-greater percentage of the population to get some treatment to improve mental health? Are the patients who come to a psychiatric clinic via the common traditional channels (referral by self, relative, friend, family doctor) more or less treatable than those produced by newer "case finding" methods in the community?

The setting in which this study was done is unusual in having had a psychiatric clinic as part of comprehensive health services for about 15 years. For this reason there was no large reservoir of patients needing and wanting psychiatric services which they could not afford. Note that 10 per cent of the patients identified as emotionally dis-

turbed and in acute distress already had been seen in the psychiatric clinic. Many of the others in this group undoubtedly have been referred but will never be seen in psychiatry for a number of reasons, among which may be the following: (1) they have too much invested in their roles of being (physically) sick; (2) they have major physical illnesses which they and their doctors use to ignore the emotional illness; (3) they are terrified by the idea of mental illness ("craziness"); (4) there is often a payoff for "real," i.e. physical, illness, but not for emotional disturbance from family, friends, doctors, insurance companies. The fact that 90 per cent of these patients have never gotten to the psychiatric clinic demonstrates that non-psychiatric physicians have been treating and will continue to treat the bulk of the emotionally-disturbed people in the population.

While we have demonstrated that emotionally-disturbed patients who are seen in psychiatry reduce their use of other medical services, we are still unable to determine whether this would hold true for all those patients identified by our double-screening technique as likely candidates for psychotherapy.

One should be cautious in using statistics from mental health clinics when they deviate from the averages reported by most other clinics. It has often been reported that about one per cent of a population will seek psychiatric services per year. The Group Health Insurance study¹ showed the pattern of response that is usually seen when a population is offered low-cost psychiatric services for the first time: increased utilization for the first few months due to an accumulation of need for such services. After that, the demand stabilizes. Active "promotion" of psychiatric benefits did not increase the utilization of psychiatric services in their population.

It is possible to report a much higher

rate of utilization, e.g., 5 per cent/year, if one organizes his psychiatric clinic in the following manner: (1) "crisis" orientation; (2) very brief therapy and counselling; (3) representing the psychiatric staff member as "your friendly family counselor"; (4) fostering dependency relationship by encouraging patients to return frequently—whenever they have to make decisions, feel anxious or depressed, etc.; (5) counting each family member as a separate patient when a family is seen together; (6) most of all—by counting each return to the clinic a "new patient." Unfortunately, the higher the percentage, the more effective the service.

Antes muerto que mudado (death rather than change), a Spanish proverb quoted by Lichtenstein⁹ in his classic monograph on identity, dramatizes the tremendous dynamic force behind the human being's need to maintain his identity—a force that has priority over all forces motivating a person's behavior and life style. Many otherwise baffling aspects of the behavior of individuals, groups and nations become clear if this force is recognized. Patients do not want to change, in fact resist change, even though their lives are full of misery and pain. A psychotherapist, then, is relatively helpless unless the patient is highly motivated, i.e., in a great deal of "pain." Getting a patient to the office of a psychotherapist is likely to be a waste of everybody's time unless the patient is "ready" or motivated for some kind of change. It is, of course, the psychotherapist's job to foster and capitalize on every shred of motivation he can find. Many emotionally-disturbed people in the community may seem to "need help" but are not at all interested in change. This is certainly true of a high percentage of alcoholics, "hippies," addicts, "psychopaths," criminals and many other types whom the community at large thinks "need help."

The assessment of the effectiveness of

psychotherapy has always presented great difficulties, conclusions varying from "psychotherapy is worthless"⁶ to the behavior therapists' claim of as high as 86-95 per cent effectiveness in 30 interviews or fewer.¹¹ By far the best investigation of brief psychotherapy was done by the Tavistock group, reported by Malan.¹⁰ We need much more high-quality research of this kind in assessing the value of mental health programs.

It is interesting to note the few differences between blue-collar and white-collar workers (Table 2). The blue-collar patients are more apt to be in only three (of 14) categories: hysteric; panic and anxiety attacks; and depressive character; and less likely to be obsessional. Otherwise, the two groups are comparable in percentages in the other neurotic and character-disorder categories and in all the psychotic categories. The "pseudoneurotic schizophrenic" category defines a group of patients who have a wealth of symptoms of many kinds. These patients are the ones that seek professional help constantly, who "never get well" and may make up a large percentage of those long-term patients in the office of every physician, psychotherapist and psychoanalyst.

The similar percentages of incidence of psychoses in blue-collar and white-collar groups may reflect the greater impartiality of the computer than the clinician, if we accept the contention of Hollingshead, *et al.*,⁸ that middle-class psychotherapists tend to over-diagnose psychosis in patients of lower socioeconomic classes as compared with those of middle or upper classes.

Summary

During a six-month period, 10,667 patients taking the Automated Multiphasic Screening Examination (Kaiser-Permanente Medical Center, San Francisco) were given a computerized psychological test as a

routine part of that screening. The tests revealed that 3,682 patients, or one third, had evidence of neurosis, personality disorder, or psychosis. Of these, 822 (or 7.7 per cent of the total Multiphasic patients tested) also had high degrees of "emotional distress." The 32 internists conducting the Multiphasic follow-up examinations received computer-printed "consider-rules" suggesting referral to psychiatry for half (411) of these patients, while the other half served as a control group and did not have such a "consider-rule."

It was found that attempts at early detection of emotional problems did not generate more psychiatric clinic patients than those generated through routine medical practice in this setting. There was considerable resistance on the part of physicians to the "artificiality" of referral by automated procedures, and there was a comparable rejection by patients of a referral made as a result of such procedures.

The population selected by this automated psychological screening method were high utilizers of medical services. Where neurotics tend to use outpatient medical services, psychotic patients tend to use inpatient medical services. Patients with personality disorders seem to use both. No differences in utilization rates were found in terms of blue collar versus white collar, or urban versus suburban.

The implications of these findings are: (1) attempts at early detection of psychiatric problems will not create as great a demand for psychiatric services as might be expected; (2) whereas many patients seeking outpatient medical treatment may be reflecting neurotic problems, psychotic patients often manifest symptoms which so simulate a variety of baffling problems that they are hospitalized for medical diagnostic workups. Patients with personality disorders seem to require both outpatient and inpatient attention in above-average amounts.

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Effect of a Short-term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program

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A pilot study was conducted to measure the effect of a short-term outpatient psychiatric therapy benefit on the utilization of general medical services at Group Health Association of Washington, D. C. (GHA), a prepaid group practice medical program. The study group consisted of 256 patients who were referred for such outpatient therapy and who were GHA members for a full 12-month period both before and after the psychiatric referral. Study patients experienced a marked reduction during the year after referral as compared with the prior year in the utilization of GHA nonpsychiatric physician services and laboratory or x-ray procedures. The reduction in number of patients seen was 13.6 per cent for nonpsychiatric physician services, and 15.7 per cent for laboratory or x-ray procedures. In terms of visits made, reduction was approximately 30 per cent for each of these services. Basic finding of reduced utilization was still obtained when factors of age, race, sex, psychiatric diagnosis, and number of therapy sessions attended under benefit were taken into account. Results support findings of reduced utilization in other studies and suggest more efficient utilization of appropriate medical services as a result of short-term outpatient mental health benefit in prepaid health plan settings.

ONLY IN THE PAST decade have significant increases in mental health benefits been included in the rapid growth in health insurance protection through private voluntary insuring organizations. Since 1963, the National Institute of Mental Health (NIMH) has actively stimulated this development by encouraging the expansion of private voluntary health insurance coverage for mental health.⁵ In a collaborative effort with the

NIMH, the United States Civil Service Commission, which administers the Federal Employees Health Benefits program,¹¹ requested insurance carriers and health plans participating in that program to incorporate new or improved mental health benefits, particularly coverage for outpatient services, into their existing benefit structures.

A total of some four million people are enrolled in community prepaid group practice health plans which are essentially comprehensive in their health coverage.⁶ Prior to 1960, when the federal employees program went into effect, these plans in the main were without prepaid mental health benefits. However, all federal employees enrolled in these plans now have some mental health coverage, including outpatient benefits; and similar coverage is also available to other members and contractor groups in these plans.

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11 The Federal Employees Health Benefits program, which became effective in 1960 under an Act of Congress, is the largest employer-sponsored contributing health insurance program in the world covering more than seven million persons, including employees, annuitants, and dependents.

With the adoption of mental health benefits in prepaid group practice plans, it has become possible to evaluate to some extent the effects that these benefits might have on patient utilization of nonpsychiatric medical services covered by the plans.^{1,2} Group Health Association of Washington, D.C. (GHA) cooperated with the Biometry Branch of the NIMH in conducting a small pilot study directed towards this question. This paper reports on the results of that study which is based on the first year's experience with a mental health benefit at GHA before benefits were expanded and before the total population of GHA was included.

Setting and Nature of Short-Term Mental Health Benefit

The Group Health Association of Washington, D.C. is a comprehensive prepaid group practice program whose participating population resides almost entirely in the metropolitan Washington, D.C. area and is comprised of three groups: federal government employees, D.C. transit workers, and general members. In November 1964, GHA included a limited outpatient mental health benefit in its structure of benefits for its government employee group who then comprised 66 per cent of the GHA participant population of approximately 54,000. In January 1965, this benefit was extended to the general members who accounted for 18 per cent of the participant population. Thus, 84 per cent of the GHA population had some coverage for short-term outpatient psychiatric care at the inception of the partially prepaid benefit. Acute short-term hospital care had previously been part of the benefit structure.

At its initiation, the GHA mental health benefit offered under prepayment was essentially as follows: GHA paid up to 15 dollars for each of 10 therapy sessions in a membership-year for outpatient treatment of acute mental illness and emotional disorders

subject to significant improvement through short-term outpatient therapy.* A GHA screening psychiatrist determined eligibility for referral on benefits. When the patient was referred by a GHA nonpsychiatric physician to the GHA screening psychiatrist for evaluation purposes as to eligibility for benefits, there was no charge to the patient for that visit or visits. During the study period, a patient could also self-refer to the screening psychiatrist. An evaluation of the patient's psychiatric condition was made by the screening psychiatrist and, on the basis of his diagnostic impression, he recommended appropriate psychiatric care where indicated, and he determined whether GHA coverage for benefits could be approved. If short-term therapy was authorized under the benefit, the patient was referred to psychiatrists or other mental health disciplines. If the condition was chronic, and hence not covered by the benefit, referral could still be made to another agency or psychiatrist, but no payment would be made by GHA for such care.

Study Design

The basic study plan was to compare, for the case group under study, the utilization of GHA medical services before and after each patient was referred on benefits for short-term outpatient psychiatric therapy. The "before" period was the 12-month interval immediately preceding the date of referral by the screening psychiatrist. It was considered likely that virtually all of the patients undergoing therapy would have completed such care during the first three months immediately following referral. Since such therapy was apt

* The limit of 10 therapy sessions was a renewable benefit each membership-year (i.e., year beginning with each anniversary date of joining the plan). Thus, if therapy was initiated towards the end of one membership-year and carried into the next, the patient could actually have as many as 19 sessions for the same referral.

to affect the utilization of GHA services during this period, and to allow sufficient time for completion of the therapy on benefits, the "after" period of 12 months' duration was taken to begin three months following the referral date. Thus, the records for each study patient were reviewed for a 27-month exposure period, although the three-month "psychiatric therapy interval" was not to be included in the "before-after" analysis of medical services utilization.

For purposes of the study, it was desirable that the study group be confined to persons who were covered by the same mental health benefit. It was, therefore, decided to limit the study group to all patients enrolled under the "high option" or "premium" plan who were referred on benefits for psychiatric therapy during the first year the benefit structure was in effect.* Thus, as a by-product, the results of the study could provide a baseline for any future studies based on a revised benefit structure. (After the first year, the GHA mental health benefit was substantially increased and broadened.)⁷

Since the GHA mental health benefit during the study period applied only to the federal employee and general member groups (including covered family members), they comprised the study population. The GHA medical records for these enrollees were reviewed by GHA staff to identify all patients who were referred to, and seen by, the screening psychiatrist during the period November 1, 1964 through October 31, 1965, the first full year in which the psychiatric benefit was in effect. To protect the confidentiality of the patient, individuals were not identified by name to the study staff. Also, it should be noted that the confidential psychiatric notes are not part

of the medical record and were not made accessible for this study.

A total of 726 patients (excluding GHA staff and dependents) were referred to the screening psychiatrist. Of this total, 409 patients were excluded from the study because they were judged ineligible for coverage under this benefit or because they overtly refused psychiatric care. Specifically, 161 were judged not to be in need and hence not referred for outpatient psychiatric care; 197 were referred for psychiatric care but not on benefits; referral was deferred for 45 patients; and 6 patients who would have been referred on benefits overtly refused to accept such care.

The records for the remaining 317 patients seen by the screening psychiatrist were reviewed for the 27-month period referred to earlier. From this total, 61 were eliminated from the study as follows: 57 cases were not available for the full 27-month period (35 began membership less than one year prior to the date seen by the screening psychiatrist, and 22 terminated their membership within the 15-month period following that date); for four patients the files were not available. This left 256 patients who comprised the study group. Of the final study group, 197 were enrolled in the federal employee program and 59 were general members—approximately in the same ratio to one another that these two groups comprised in the total GHA population.

As a point of interest, the age distributions were examined for the 409 patients ineligible for benefits and the 61 eligibles who did not otherwise meet the study criteria. The age distribution for the former group was found to be very similar to that of the 256 study patients; however, the latter group of 61 patients had a somewhat younger age distribution than the final study group.

Data extracted from the medical records were counts of all visits to GHA physicians

* Under the "low option" or "standard" plan, GHA paid up to 10 dollars (as compared with 15 dollars under "high option") per therapy session. Only about 10 per cent of the GHA members are enrolled in the "low option" plan.

for medical care, all visits for x-ray and laboratory procedures, as well as the number of visits made for psychiatric therapy under the mental health benefit. Other data abstracted for each patient, where available, were age, race, sex, and psychiatric diagnostic impression. Information on psychiatric and nonpsychiatric hospitalizations recorded in the medical record was also extracted. However, study data on hospitalizations were incomplete because such information was not generally recorded on patients who were hospitalized outside of GHA auspices. Also, during the period of study, the GHA hospitalization information was not consistently available in the progress notes which formed the primary source of data for this pilot study.

Results

The distribution of the study population by age, sex, and race is shown in Table 1. Approximately 70 per cent of the study

group were from 25 to 64 years of age at time of referral on psychiatric benefits. In contrast, only 50 per cent of the total GHA participant population (in the federal employee and general groups) were in this age group during the study period.³ About 60 per cent of the study group were female, which was slightly higher than the proportion of females in the total GHA membership. With respect to race, about 83 per cent of the study group were Caucasian. Although no precise data on race are available for the total GHA membership, the proportion of Caucasians in the total membership is estimated to have been appreciably less than that in the study group. Specific psychiatric diagnosis for each patient was not uniformly recorded in the medical records. However, from information which was recorded, based on the evaluation of the screening psychiatrist or the psychiatrist providing therapy, it was possible to classify the psychiatric diagnostic

TABLE 1. Distribution of Study Group by Age, Race, Sex, and Psychiatric Diagnostic Impression

Patient characteristics	Number	Per cent*
Total study group	256	100.0
Age group (years)		
0 - 14	22	8.6
15 - 24	49	19.1
25 - 44	97	37.9
45 - 64	82	32.0
65 +	6	2.4
Race		
Caucasian	210	82.7
Other	44	17.3
Unknown	2	
Sex		
Male	100	39.1
Female	156	60.9
Psychiatric impression		
Psychosis	40	20.7
Psychoneurosis	106	54.9
Personality disorder	21	10.9
Transient situational personality disorder	22	11.4
Other	4	2.1
Unknown	63	

* Based on total patients for whom characteristics were known.

TABLE 2. Comparison of Number of Patients Seen and Visits Made During Year Before and Year After Psychiatric Referral by Type of Service

Type of Service (nonpsychiatric)	Patients Seen (N = 256)			Visits Made*		
	Year before referral	Year after referral	Per cent change	Year before referral	Year after referral	Per cent change
Physician services	243	210	-13.6	1264	876	-30.7
Laboratory or x-ray	210	177	-15.7	795	558	-29.8

* Each visit for laboratory or x-ray services was counted only once regardless of the number of procedures performed at each visit.

impression into broad categories for three fourths of the study group. Among those for whom the diagnostic impression was determined, 21 per cent were classified psychotic, 55 per cent psychoneurotic, 11 per cent with personality disorders, 11 per cent as having a transient situational personality disorder, and 2 per cent were considered to have some other psychiatric problem.

Initially, the data were analyzed separately according to the specific medical department or ancillary service in which the patients were seen (i.e., internal medicine, other nonpsychiatric medical department, laboratory, x-ray). Almost 95 per cent of the visits by the study patients for physician services were made to the department of internal medicine. However, since the study findings for visits to internal medicine were similar to those for other nonpsychiatric medical departments, the data for all medical departments were combined in the analysis presented here. Similarly, with respect to ancillary services, the findings on visits for laboratory procedures were essentially the same as those for x-ray visits, so the data for laboratory and x-ray services were also combined.

Study findings presented below compare separately the physician and ancillary (laboratory or x-ray) services received by the study group during the 12-month periods before and after referral on psychiatric benefits, by age, race, sex, diagno-

sis, and number of psychiatric therapy sessions attended on benefits. It was not possible to conduct a "before-after" analysis with respect to utilization of psychiatric services. Although some psychiatric counseling was provided on a fee-for-service basis prior to the initiation of the mental health benefit, there was no psychiatry department as such at GHA at that time and, therefore, no comparable or meaningful basis for comparison. Thus, the "before-after" analysis was limited to utilization of nonpsychiatric medical services.

Table 2 shows the number of study patients who received care from the various GHA departments, except psychiatry, and the number of visits made to these departments during the "before" and "after" periods. Also shown is the per cent decrease from the "before" period to the "after" period with respect to number of patients seen and number of visits made. Each visit for laboratory or x-ray services was counted only once regardless of the number of procedures performed at each visit.

It is clearly evident from these data, in terms of persons seen and visits made, that medical and ancillary services were each provided to more of these patients and more frequently before psychiatric referral than after. Thus, the reduction in the number of patients seen by the nonpsychiatric medical departments was 13.6 per cent, and for laboratory or x-ray procedures, 15.7 per

TABLE 3. Per cent Decrease During Year After Referral as Compared with Prior Year in Utilization of Nonpsychiatric Physician Services and Laboratory or X-ray Procedures, According to Patient Characteristics and Psychiatric Therapy on Benefits

Patient characteristics and therapy received	Number in study	Per cent decrease after referral*			
		Patients seen		Visits made	
		Physician services	Lab or X-ray	Physician services	Lab or X-ray
Total Study Group	256	13.6	15.7	30.7	29.8
Age (years):					
0 - 14	22	4.5	21.1	23.8	35.6
15 - 24	49	17.4	15.8	36.1	33.0
25 - 44	97	16.5	17.9	29.7	27.4
45 - 64	82	11.5	13.0	31.7	30.8
65 & over	6			20.6	20.0
Race:					
Caucasian	210	13.1	15.9	26.1	30.5
Other	44	14.0	14.7	49.0	25.6
Unknown	2				
Sex:					
Male	100	16.1	23.5	37.8	47.6
Female	156	12.0	10.9	26.0	18.0
Psychiatric impression:					
Psychosis	40	25.0	28.6	35.0	29.0
Psychoneurosis	106	10.0	6.7	23.4	23.3
Other	47	4.4	12.2	46.9	32.2
Unknown	63	19.0	26.7	24.7	41.5
Psychiatric therapy sessions:					
None	70	16.9	24.1	39.2	22.6
1 - 9	75	12.7	18.5	30.4	23.8
10 or more	104	11.0	6.0	23.3	35.3
Unknown	7			50.0	44.4

*Per cent not shown in any cell where base (number before referral) was less than 10.

cent. Similarly, in terms of number of visits made, the reduction was approximately 30 per cent both for physician services and for laboratory or x-ray procedures.

Viewing the reduction in utilization another way, the average (mean) number of visits made by the 256 study patients, during the "before" and "after" periods, respectively, were 4.94 and 3.42 for physician services, and 3.11 and 2.18 for laboratory or x-ray procedures.

Overall, the study group experienced a total reduction of some 30 per cent in the number of visits made for physician and ancillary services. The difference between the periods before and after referral with

respect to the number of patients seen was statistically significant ($P < .001$)* for physician services as well as for laboratory or x-ray procedures. Similarly, for each of these services, the reduction in the mean number of visits was also statistically significant ($P < .001$).†

The study data were analyzed further to determine whether the observed decreases after psychiatric referral held for various subgroups of the study population. Thus,

* McNemar's chi-square test for correlated samples was used.

† The two-tailed t-test of paired (before-after) differences was used.

TABLE 4. Number and Per cent of Persons with Fewer, Same, or More Visits in Year After Referral Compared with Year Preceding Referral, by Type of Service

Visits before and after referral	Physician Services		Laboratory or X-ray	
	Number	Per cent	Number	Per cent
Total study group	256	100	256	100
Fewer visits in year after referral	152	59.4	134	52.3
Same number of visits both years	42	16.4	50	19.5
More visits in year after referral	62	24.2	72	28.1

for both physician services and ancillary services, the "before" and "after" periods were compared with respect to the per cent change in number of persons served and total visits made according to age, race, sex, psychiatric diagnostic impressions and number of psychiatric therapy sessions attended under benefit.

The findings presented in Table 3 clearly show the overall consistency of reduction in utilization of the physician and ancillary services by the study group. Although some variation existed in the extent of decrease (partly due to small numbers in some cells), the pattern of reduced utilization of these services held throughout each of the distributions.* There was par-

ticularly little variation in the per cent change by age. It is also of interest to note that patients who did not avail themselves of the short-term outpatient therapy benefit generally showed as great a relative reduction in utilization of medical services as did those who received the full benefit of at least 10 sessions.

Another indication of the consistency of reduced utilization of physician and ancillary services after psychiatric referral is evident in the data in Table 4. Here, a determination was made as to whether each patient made fewer, more, or the same number of visits during the 12-month period after psychiatric referral as he or she made during the prior year for physician services or for laboratory or x-ray procedures. Only about one fourth of the study patients made more visits for physician services after referral than before in contrast with the almost 60 per cent who made fewer visits after referral. Similarly, only 28 per cent of the patients made more visits for laboratory or x-ray procedures after referral than before, while 52 per cent made fewer such visits. Both of these differences were statistically significant ($P < .001$).^{*} When the patients were grouped according to the actual number of visits made in the year preceding referral, this pattern of fewer

* For both of the service categories, statistical tests of significance were performed comparing the various age groups, Caucasians with those of other races, males with females, the various diagnostic categories, and those who had no psychiatric therapy sessions under benefit with those who had 10 or more sessions. With respect to persons seen, each patient was classified as to whether or not he showed a "before-after" reduction in number of visits made, and a chi-square test was used to compare the dichotomous distributions for the various comparison groups. None of these comparisons was significant at the .05 level. With respect to visits made, either an analysis of variance or a two-tailed t-test was made of the difference between the comparison groups in the mean "before-after" reduction in number of visits. In only one instance (the greater reduction observed among males than females in average number of laboratory or x-ray visits, $P < .02$) was the observed difference statistically significant at the .05 level.

* The chi-square test was employed to test the equality of the number of patients showing a decrease in number of visits with those showing an increase.

visits held for virtually all groups of patients who had at least two visits in the prior year for physician or ancillary services. The greatest relative reductions occurred among those who made the most visits during the prior year. Thus, of the 81 patients who made more than five visits for physician services during the year preceding referral, 64 (79 per cent) made fewer visits in the post-referral year than they did in the prior year.

Discussion

The consistent results of this pilot study clearly indicate that the short-term outpatient psychiatric benefit at GHA was associated with a decrease in the utilization of physician and ancillary services under the plan. Not only was there a decreased utilization following psychiatric referral for the study group as a whole, both with respect to the number of persons seen and the number of visits made, but this decreased utilization held—to a greater or lesser degree—for all subsegments of the population studied.

Of some interest in this regard is the relationship between utilization of physician and ancillary services at GHA and the number of therapy sessions attended under the short-term psychiatric benefit. Note has been made of the fact that the study patients who did not attend any outpatient therapy sessions under benefits (although referred by the screening psychiatrist for such care) showed as great a relative reduction of medical services utilization as did those who received all or part of their authorized therapy. This finding would seem to imply that the visit to the screening psychiatrist alone may have had a beneficial effect on the patient, at least to the extent that the patient apparently had reduced need or desire for physician or ancillary services following the screening. However, it should be noted that some patients referred on benefits may have elected to ob-

tain their psychiatric therapy outside the GHA benefit structure at their own expense. Unfortunately, the GHA records do not ordinarily reflect such outside care. In any event, it is clear that whether or not the referred patients as a group actually availed themselves of the benefit provisions, they showed a reduced subsequent utilization of general medical services provided by the group practice plan.

It is reasonable to assume that the observed reduction in utilization of physician and ancillary services at GHA to a large extent reflects a reduced need or desire for such services, rather than a shift by the patients to other sources for their medical attention at additional cost to themselves (although, undoubtedly, some such shifting did occur). This assumption is based upon the fact that these patients continued to maintain their GHA membership throughout the 27-month study period, and that the very great majority did return to GHA for at least some medical attention during the "after" period.

When viewed in terms of the effect on the provider of services, the reduction in use of physician and ancillary services at GHA would seem to imply a reduction in cost which would otherwise occur in the provision of such services and, theoretically, a more efficient utilization of appropriate services. There was no attempt to do any cost-benefit analysis in this study, the primary purpose of which was directed at utilization without regard to costs. However, an inference could be made that the cost savings due to reduced utilization would be reflected in the entire benefit structure without setting forth dollar amounts.

Comment should be made about the possible effect of hospitalization on the study findings, since a question might be raised as to whether or not there was appreciably more hospitalization in the period after psychiatric referral than in the prior-referral year. As mentioned previously, during the

period of study, the GHA hospital records were not totally coordinated with the medical record, which was the principal data source for this study. Therefore, the effect of episodes of hospitalization on the study findings could not be evaluated. With respect to psychiatric hospitalization, however, since the study group excluded all patients whom the screening psychiatrist considered to have a chronic condition requiring inpatient or long-term outpatient psychiatric care, it is very unlikely that more than a handful of study patients would have required such hospitalization. In any event, the study findings were of such magnitude and consistency that they are unlikely to be materially affected by the factor of hospitalization.

Another consideration relates to the study design whereby each patient was used as his own control in the "before-after" comparison. The absence of a suitable control group in this pilot study, against whom the "before-after" findings of the case group could be compared, limits the conclusions which can be drawn at this time; however, efforts are underway in a broader study to obtain similar data for such a comparison group. The question which arises here is whether the study patients, having already received medical attention one year, would be likely to require more or less care in the following year. If need for less care were to be expected, this might account, at least in part, for the reduction in utilization observed among the study group. However, the GHA experience in the past indicates that patients using the plan, with its emphasis on preventive services and early detection of chronic disease, tend to use the services increasingly in subsequent years. This is supported by the following data for the total GHA experience around the study period, which show a level or rising per capita utilization in contrast to the observed finding of markedly reduced utilization by the study group.^{3, 4}

Year ending September 30	GHA Per Capita Utilization Office		
	Con- sul- ta- tions	Labora- tory	Radio- logy
1963	3.65	3.88	1.08
1964	3.77	4.43	1.08
1965	3.77	5.06	1.14
1966	3.71	5.25	1.12

Follette and Cummings² also studied medical utilization before and after psychiatric therapy in a prepaid health plan setting, namely the Kaiser Foundation Health Plan in the Northern California Region. Their case group consisted of persons who received psychotherapy defined as any contact with the plan's department of psychiatry. The medical utilization for the year prior to the initial contact with that department was compared with the utilization for each of five subsequent years, both for the case group and a matched control group who did not receive psychotherapy. The outpatient medical services in that study included visits to outpatient medical (nonpsychiatric) clinics and contacts for outpatient laboratory and x-ray procedures; however, these three types of service were lumped together in the analysis. Despite differences in the setting, benefit structure, mental health disciplines utilized, and study design from those of the GHA study, Follette and Cummings also found a significant decline in utilization of medical services following psychotherapy.

A further, although limited, indication of reduced utilization of general medical services following outpatient psychotherapy is contained in an unpublished report of another study. In 1965, the Health Insurance Plan of Greater New York (H.I.P.) instituted, as a demonstration project, a mental health service which, upon referral by a group physician, provided an outpatient psychiatric treatment benefit in one of its medical groups. One section of the final report of that project¹ submitted by H.I.P. to

the National Institute of Mental Health, which partly supported the demonstration project, contains an analysis of the relationship between psychiatric treatment and the use of medical services including family physician office visits, specialist office visits, and x-ray and laboratory services. Due to sample size limitations and other considerations, the results of this analysis were viewed in the report as exploratory only. The "treatment" group (those seen in the mental health service for consultation or treatment) and three comparison groups were employed in a "before-after" analysis of medical utilization for periods covering one year before the appropriate "study" or "consultation" date and each of two years after. Although the report notes that the analysis did not demonstrate a consistent pattern across all comparison groups, it also states that the analysis indicated "... some tendencies pointing to lower medical utilization in the group to whom psychotherapy was available."

The supporting evidence of the Kaiser, H.I.P., and GHA studies strengthens the hypothesis of reduced utilization of medical services, and more efficient utilization of appropriate services, as a result of short-term outpatient mental health benefit in prepaid health plan settings.

On the basis of the findings of the GHA study presented in this paper, the authors are now initiating a broader study which will include a "before-after" evaluation of

the utilization of GHA medical and hospital services by all family members of patients referred on psychiatric benefit and will also employ one or more comparison groups.

Acknowledgments

The authors wish to thank Mrs. Josephine Tate (GHA) for her assistance in abstracting the study data; Mr. Robert F. Woolson and Mrs. Warnilla Cook (both of the Biometry Branch, NIMH) for their assistance in the analysis; and Mrs. Mildred Arrill (Division of Mental Health Service Programs, NIMH) for her consultation.

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STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, SUBMITTED BY
KENNETH B. LITTLE, EXECUTIVE OFFICER

This is a statement by the American Psychological Association expressing its concern that the important relationships between psychology and the field of health be fully understood by those planning for the future of our national health effort. Four main points are presented:

That the health effort of the nation, to be truly effective, must plan for dealing with the emotional and behavioral factors contributing to or resulting from illness.

That most mental health problems are not medical problems but psychological ones.

That psychologists by training are eminently qualified to deal as practitioners with such problems.

That in the long run the health needs of the public will best be served by policies encouraging free access to a variety of competing modes and concepts of practice.

Although it is difficult to determine the number of people suffering from mental disorders, it has been generally accepted that approximately 10% of the noninstitutional population is, at any given time, afflicted with some form of mental or emotional disturbance of sufficient intensity to require professional care. Also, it is generally estimated that half of the patients treated by general practitioners have emotional or behavioral complications (Follman, 1970). In addition mental illness, if not detected and treated, may interfere significantly with a person's acceptance of and response to other treatment for physical illness. Failure in the past to provide for the determination of the extent and significance of these disabling emotional disorders in the physically ill and the physically healthy has led to waste of expensive medical resources accompanied by either serious delay in, or neglect of, appropriate treatment.

Further, if one of the goals of a comprehensive national health planning effort is to diminish the need of individuals for hospitalization, it must recognize the significant number of health problems arising because people smoke too much, drink too much, eat too much of the wrong kinds of food, drive too fast, worry too much, push themselves too far, or too readily yield to ultimately debilitating outlets for escaping their problems of living. Ulcers, complications from diabetes and other diseases, cardiovascular problems leading to premature death—or to permanent invalidism, especially among the elderly—may all be brought on or exacerbated by the stress of chronic anxiety. We firmly believe that an attack on the root causes of self-defeating behavior is as important to the health of the nation as is inoculation for diphtheria and smallpox.

What role can psychologists play in this health maintenance approach? Much of it hinges on the approach to the health problems described above. Psychologists are often confused with their medical colleagues, the psychiatrists, particularly since the services of a sizable number of psychologists parallel those of psychiatrists as they deal with problems of mental disturbance. (Psychologists have been licensed or certified in 43 states to perform psychological services. Many of these services—including psychotherapy—are similar to those performed by psychiatrists.)

Psychiatrists are trained first as physicians and their approach to mental problems has a medical orientation. Psychologists, however, are typically trained in graduate schools of arts and sciences in programs leading to a Ph. D. degree. Psychologists by training tend to view symptoms such as discomfort, anxiety, unhappiness, as the result of an individual's failure to deal effectively with life's problems. The symptoms are frequently signs, not of a medical illness, but of ineffectiveness in coping. With this kind of perspective, psychologists are breaking away from traditional, somatically-oriented solutions to health problems and attempting to deal with problems of living by a variety of procedures flowing from the science of psychology. The attempt is to provide individuals with more effective behavior patterns or more constructive alternatives for the use of existing behavior.

Psychologists have for many years been concerned with individual differences in ability and aptitude. They have developed tests and other instruments for understanding and assessing such dimensions within individuals. From the information gained from such tests, they have helped individuals to utilize their relatively strong abilities and encouraged them to avoid areas in which their aptitudes do not augur adequate performance. Similarly, psychologists have

used a variety of procedures to modify the skills of individuals so that they may be maximally effective in coping with problems with which they are confronted. It is not surprising in the light of this expertise that psychologists have been significantly involved in personnel selection and in the design and evaluation of training programs in the armed forces and industry.

We would also stress the uniquely significant role being played by psychologists in psychotherapy and other forms of behavior modification. It is encouraging that the new behavior therapies have been successful enough to represent a breakthrough in dealing with a large variety of behavioral problems from classroom management to phobias. These approaches typify the psychologist's goal of emphasizing the individual behavior patterns appropriate to given situations. The approaches flow from the fundamental knowledge about psychological processes that have been gained from the laboratory and brought to maturity in practice. Learning has been a major subject matter area in experimental psychology for at least fifty years, and psychologists have played a leading role in education throughout that time. (It should be pointed out that many of the helping procedures are relatively short term and can be performed with minimal training. Teachers and parents, for example, can be taught the procedures almost on a prescription basis. Thus these forms represent relatively inexpensive investments in the health of the nation. We would hope their use would contribute to curbing the cost of any national health program.)

The psychologist with a social and community orientation can also make contributions to the overall health picture by efforts to make the social structure more supportive of the individual's abilities.

The role of the psychologist in the long range view of health planning thus is seen as one of researcher, teacher, and provider of services. As a researcher the psychologist has, as we have noted, developed conceptually new ways to view what in the past were considered to be medical problems. Research activities of psychologists are contributing to the fundamental understanding of a number of health-related conditions and behaviors. The seminal work of psychologists Schachter with obesity, Shakow on schizophrenia, and Miller with autonomic conditioning, etc., are significant advances that will enable us to deal more effectively with factors contributing to poor health and disease.

Psychologists are to a large extent teachers. As many as 1,500 of them are employed in medical schools in teaching and research capacities, and many more are engaged in training the 2,000 doctorates, the 5,000 masters and the more than 30,000 bachelors degree recipients in psychology each year.

Third, psychologists are performing direct mental health type activities in a wide variety of institutional settings. Approximately 18,000 psychologists presently hold statutory or non-statutory credentials regulating psychological practice in the various states. While many of these are currently employed in non-profit institutional settings and a small minority may be trained in non-health related professional activities, the great majority represent a pool of professional personnel competent in the rendering of personal mental health services to those in need. A corollary fact is that 85% of psychologists have their major employment in public service settings (schools, universities, hospitals, public agencies and the like) while under 10% are full-time self employed. Many of those in institutional employment may do additional part time consultation or service for a fee.

We have pointed out that psychologists have approached the health area with some fresh perspectives and have provided alternative solutions and a healthy competition. We firmly believe that psychology has significant contributions to make to the broad area of health care. The scope of planning efforts for the health programs now being considered implies a major system that may affect the shape of health care for a long time to come. We urge that this system be kept open, that various health professions be allowed to participate on equal terms so that new techniques by all professional groups may be evaluated competitively for cost effectiveness. We believe that psychology is developing and will continue to develop high quality effective procedures to deal with health problems. We feel that the health of the country will profit if we, and other professionals who will make their contributions from non-traditional viewpoints, are not frozen out of the health system prematurely. Competition provides the arena for evaluation of effectiveness; it also serves to inhibit needless cost increases.

The message of the foregoing remarks is that the inclusion of mental health care in national health planning may be an inexpensive form of preventive medi-

cine. Studies on the effect of short term psychotherapeutic intervention on medical utilization have suggested that it tends to reduce the need for expensive medical services. Mental health treatment does not necessarily entail the stereotyped long term interaction of a troubled individual with a high priced professional. New procedures are being developed that are short term and may be performed by professionals of various kinds at various levels of training and experience. We are encouraged that the thinking of many legislators takes a broad view of the problems of health. Consideration of the health maintenance organization concept is a commendable option to break impasses in the delivery system. We hope that the general health maintenance concept forms a foundation for all health legislation in the interest of both cost and effectiveness.

The CHAIRMAN. The next witness will be Mrs. Hilda Robbins, member of the Public Affairs Committee of the National Association for Mental Health and president of Pennsylvania Mental Health, Inc.

STATEMENT OF HILDA ROBBINS, MEMBER, PUBLIC AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR MENTAL HEALTH; PRESIDENT, PENNSYLVANIA MENTAL HEALTH, INC., FORT WASHINGTON, PA.

Mrs. ROBBINS. Mr. Chairman and members of the committee, as Senator Long has said, my name is Hilda Robbins. I live in Fort Washington, Pa. I have been an active citizen volunteer in the field of mental health since 1956 when I was a volunteer on the wards of Norristown State Hospital. Since that time I served as trustee of that hospital for 9 years and I am on the Governor's Advisory Committee for Mental Health and Mental Retardation and, as you said, a member of the Advisory Association for Mental Health. All of this is relatively unimportant but the thing I would like to impress the members of the committee is that I speak for the mentally ill.

The National Association of Mental Health does not represent any other profession—doctors, psychiatrists, nurses, psychologists. We do not represent the hospitals or the delivery of any kind of services. Through the years it has been our purpose to work for the improvement in the mentally ill and it is for that reason that we are so vitally concerned about the recommendations that we have made today.

You have the complete testimony that we have prepared for you and we have made six specific recommendations. However, I think it safe to say that all of those six could be boiled down into two very important points:

The first is that we believe that now is the time to completely eliminate all of those discriminatory restrictions that have been placed on the mentally ill through the years; and the second is that we believe that all of this legislation should be directed toward receiving services wherever possible outside of a hospital situation.

Now, I will briefly go into the specific recommendations.

Under medicare, coverage of inpatient psychiatric service is limited to 190 days for a lifetime. There is no such limitation for physical illness.

Our position has been that it is morally indefensible to limit coverage to a group of people based on their diagnosis.

I can understand that there would have been some concern about the experience of this several years. However, you have had repeated testimony that has established the fact this is not prohibitively expensive.

In the financing care of the mentally ill under medicare and medicaid in a report that was asked for by this committee, they found medicare and medicaid illness coverages have an average length of stay over 90 days.

Therefore, it would seem that placing a lifetime limitation on medicaid of 365 days, as is currently recommended by H.R. 1, is certainly not necessary.

It is more logical to place a limitation on the number of days per benefit period with no limit on the number of benefit periods.

This would provide for a creative expenditure of Federal funds because it would motivate State hospitals to develop active treatment programs to rehabilitate the patient during the time for which Federal funds are available. It would encourage earlier discharges thus helping to avoid the debilitating effects of long-term institutionalization. However, if after a period of time the patient needs further care in an institution, a full benefit period should again accrue to the patient.

The current practice under medicaid of limiting coverage in mental institutions to those age 65 and over received comment in "Financing Care of the Mentally Ill Under Medicare and Medicaid." The report states:

Psychiatric experts consulted by the staff stressed two facts: (1) the age restriction in title XIX excluded people in age groups most likely to benefit from active treatment in the psychiatric hospital; (2) if such treatment were made available under medicaid this would contribute to the rehabilitation of young and middleaged adults and facilitate their return to the community as economically productive and useful members of society.

Last year, Senator Long, chairman of this committee, proposed including inpatient services to children up to the age of 22, and we applaud this. It certainly is a step in the right direction, but there is still a vast majority of people who need the benefits of medicaid, those people between 22 and 65.

Therefore, NAMH recommends that all discriminatory provisions relating to the care of the mentally ill under titles XVIII and XIX be removed. If, however, the Congress, in spite of the knowledge now available as to utilization and costs, believes it must limit coverage of inpatient services for the mentally ill, we recommend that such limitations relate only to length of stay per spell of illness and suggest 40 days as a reasonable period. There is no logical reason for age discrimination or lifetime limitations.

To encourage alternatives to institutional care we know that H.R. 1 provides an incentive for States to contract with health maintenance organizations. We applaud this and believe that the same incentive should be provided to community mental health centers. These centers have already conclusively demonstrated their ability to reduce institutional care. Therefore, NAMH recommends that community mental health centers be included among those organizations for which the State would receive a 25-percent increase in the Federal medicaid matching moneys.

H.R. 1 also specifically states that in order to discourage prolonged stays in institutions there should be limits on medicaid hospitalization benefits. NAMH certainly supports that concept; however, current medicaid provisions tend in the opposite direction. For example, to receive medicaid payment, inpatient services must be given in a gen-

eral hospital setting. This means that a mental health center which has been fully approved for Federal construction and staffing funds would be denied medicaid funds if it is not associated with a general hospital.

The task force on medicaid and related programs recognized the need for the general broadening of availability of services in State medicaid programs, and they recommended and I am quoting: "Innovative facilities for provision of medical care—for example, neighborhood health centers, community health centers, group practices, outpatient services of hospitals which provide neighborhood, comprehensive ambulatory care and other facilities—should be included as eligible vendors which recipients under title XIX may elect and be encouraged to use, assuming appropriate standards of health care are met."

However, you will notice in that there is no mention of the mentally ill, no emphasis on ambulatory care.

At the present time this is not a requirement under medicaid; it is not included in the medicaid plans of a number of States.

At present there are close to 500 community mental health centers. It makes good sense for these centers to become the vendors of medicaid funds. Therefore, NAMH recommends that community health centers be included among required vendors for medicaid plans for both inpatient and ambulatory—outpatient, partial hospitalization, medications, et cetera—services.

Another point where there is decided discrimination against the mentally ill—indeed, it is distressing when we are bending every effort to end discrimination in various social security amendments that this new one has been proposed in H.R. 1. In the description of an intermediate care facility, services provided to individuals under age 65 do not include services of any public institution for mental diseases or mental defects.

The foregoing plainly points out this discrimination is based not only on age but on diagnosis. Therefore, NAMH recommends that H.R. 1 be amended to include intermediate care for the mentally ill under age 65 on the same basis as the mentally retarded.

I am sure that members of this committee are aware that a substantial, though decreasing proportion of mentally ill persons require prolonged treatment and care, long enough to become an economic catastrophe to their families. We are, therefore, especially interested in the terms proposed for coverage under—for the proposed title XX, and we are frankly dismayed that the same top limits are proposed for mental illness coverage as those that prevail for medicare and medicaid.

It seems quite illogical to us to label a program "catastrophic insurance" if, in addition to the substantial deductibles and coinsurance proposed to be taken off the bottom, there are also limits at the top. There is really only a layer of coverage, with patient liable for payment both below and above. Therefore, we recommend that there be neither coinsurance nor limitation on coverage of those few unfortunate people who become entitled to the benefits of title XX.

I would point out here—this is not in my testimony—that indeed it might be reasonable to assume that a person would be covered up to, say, \$2,000 to meet their first payment. However, as you have solicited

information from your questions today, it is a rare insurance policy that has complete coverage for mental illness. So in many cases the same thing of early payment that is available for physical illnesses is simply not there for the mentally ill.

I come to the last point that we are recommending: In some States medicaid funds have gone to the general treasury rather than into the State's mental health budget. We understand that several States are now in the process of developing legislation which would make it possible for medicaid reimbursement for mental health service to be returned to the mental health program. To permit medicaid dollars which were intended for the treatment of mental illness to be diverted into a State's general fund is inexcusable. Health moneys should not be used to build highways.

Therefore, NAMH recommends that within 1 year of the enactment of these codial security amendments, no Federal medicaid moneys for the treatment of mental illness shall be paid to States where those moneys are diverted from such treatment. Even in those States where laws dictate that such moneys must be received into general revenue funds, the State must show that appropriations for the State's mental health programs are increased by at least as much as the income from medicare-medicoid funds, plus any amounts attributable to general salary increases.

Thank you for this opportunity of being here today. I am particularly pleased to have a chance to be here. I hope that my appearance has not jeopardized our exemption and our standing with the IRS. We have become particularly and acutely aware of this when we seek an opportunity to share this kind of information from a citizens' organization that we place ourselves under extreme scrutiny from this organization. I would be happy to answer questions that you might have.

The CHAIRMAN. Any questions?

Thank you. We will try to do as much as we can to try to persuade the majority of the Senate to go along with necessary coverage for mental illness. That is the most neglected part of our program.

Mrs. ROBBINS. We certainly think it is one of the most neglected parts and I am certainly pleased to hear your sentiments.

(The prepared statement of Miss Robbins follows:)

STATEMENT ON BEHALF OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.,
PRESENTED BY HILDA ROBBINS, FORT WASHINGTON, PA.

Mr. Chairman and members of the committee, my name is Hilda Robbins. I reside in Fort Washington, Pennsylvania. I am appearing today in behalf of the National Association for Mental Health. I am a member of this Association's Board of Directors and its Public Affairs Committee. I have served on a number of other committees for this organization.

The National Association for Mental Health is the national citizens' voluntary organization working toward the improved care and treatment of the mentally ill; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illness; and for the promotion of mental health.

I have been an active citizen volunteer in the field of mental health since 1956 when I served as a volunteer on the wards of Norristown State Hospital (Pennsylvania). Since then I have served as President of the Mental Health Association of Southern Pennsylvania and am currently the President of Pennsylvania Mental Health, Inc., the Statewide citizens mental health organization. The latter two organizations are affiliated with the National Association for Mental

Health. I served also as a member, representing citizen-laymen concerns and interest, on the following bodies:

Pennsylvania Governor's Advisory Committee for Mental Health and Mental Retardation;

Montgomery County (Pennsylvania) Mental Health Mental Retardation Board;

Vice President, Norristown State Hospital Board of Trustees;

Board of Trustees—Community Services of Pennsylvania; and

Board of Directors, Horizon House, Philadelphia, Pennsylvania.

DISCRIMINATION AGAINST PEOPLE WHO ARE MENTALLY ILL IN MEDICARE AND MEDICAID

In past testimony before Congress, NAMH has opposed provisions in Medicare (Title 18) and Medicaid (Title 19) of the Social Security Act, which discriminated against people who are mentally ill. Under Medicaid, Federal payment for inpatient services in an institution for mental diseases is limited to patients age 65 and over. There is no such limitation for the physically ill. Under *Medicare*, coverage of inpatient psychiatric services is limited to 190 days *lifetime* in a psychiatric hospital. This limitation does not exist for physical illness.

Our position had been that it is morally indefensible to limit coverage to a group of people based on their diagnosis. Now there is evidence from actual Medicare experience that the limitation is not economically warranted. The study, *Financing Care of the Mentally Ill Under Medicare and Medicaid*,¹ found that Medicare mental illness discharges had an average length of stay of 39 days (median 30 days) and only 6% had a length of stay over 90 days. Therefore, placing a *lifetime* limitation on Medicaid of 365 days (including both complete and partial benefits) as currently recommended by H.R. 1, is not necessary. It is more logical to place a limitation on the number of days per benefit period *with no limit on the number of benefit periods*.

This would provide for a creative expenditure of Federal funds because it would motivate State Hospitals to develop active treatment programs to rehabilitate the patient during the time for which Federal funds are available. It would encourage earlier discharges, thus helping to avoid the debilitating effects of long-term institutionalization. However, if after a period of time, the patient needs further care in an institution, a full benefit period should again accrue to the patient.

The current practice under Medicaid of limiting coverage in mental institutions to those 65 and over received comment in *Financing Care of the Mentally Ill Under Medicare and Medicaid*. The Report states . . . "psychiatric experts consulted by the staff stressed two facts: 1) the age restriction in Title XIX excluded people in age groups most likely to benefit from active treatment in the psychiatric hospital; and 2) such treatment made available under Medicaid would contribute to the rehabilitation of young and middle-aged adults and facilitate their return to the community as economically productive and useful members of society".

Last year the distinguished Chairman of this Committee proposed including inpatient services to children, up to age 22, for reimbursement under Medicaid. This is a step in the right direction. However, it continues to discriminate against those ages 22 to 65.

RECOMMENDATION

Therefore, NAMH recommends that all discriminatory provisions relating to the care of the mentally ill under titles XVIII and XIX be removed. If, however, the Congress, in spite of the knowledge now available as to utilization and costs, believes it must limit coverage of inpatient services for the mentally ill, we recommend that such limitations relate only to length of stay per spell of illness and suggest 40 days as a reasonable period. There is no logical reason for age discrimination or lifetime limitations.

INFORMATION SUPPORTING THE NEED FOR INCLUDING MENTAL HEALTH CENTERS IN THE 25 PERCENT MEDICAID INCENTIVE IN H.R. 1

To encourage alternatives to institutional care, H.R. 1 provides an incentive for states to contract with Health Maintenance Organizations. States

¹ Published in 1970 by the U.S. Department of Health, Education, and Welfare.

under contract to HMOs and other facilities providing comprehensive health care would receive an increase of 25% (up to a maximum of 95%) in the Federal Medicaid matching formula. We applaud this and believe that the same incentive should be provided to Community Mental Health Centers, which have already conclusively demonstrated their ability to reduce institutional care. For example, the admissions to Philadelphia State Hospital from communities served by Mental Health Centers during 1967-69 fell by 21.1% compared with the year prior to the development of Community Mental Health Centers (1966). During those same years admissions to Philadelphia State Hospital from non-center served areas increased by 81% over 1966. As another example, there has been a substantial reduction in admissions to Torrence State Hospital (Westmoreland County, Pennsylvania) from communities with Mental Health Centers. In the fiscal year ending June, 1969, the average monthly admissions to Torrence was 35. Within the following year, four new Community Mental Health Centers were established in communities served by Torrence State Hospital. The average monthly admissions to Torrence declined by 25% during that year and the trend has continued downward.

This experience has been duplicated in many communities throughout the Country and is reflected in the continuing sharp National decline in State Mental Hospital population.

RECOMMENDATION

NAMH recommends that community mental health centers be included among those organizations for which the State would receive a 25% increase in the Federal Medicaid matching monies.

MEDICAID SHOULD ENCOURAGE USE OF COMMUNITY MENTAL HEALTH CENTERS

H.R. 1 would place limits on Medicaid hospitalization benefits in order to "discourage prolonged stays in institutions". NAMH supports that concept. Current Medicaid provisions, however, tend in the opposite direction. For example, to receive Medicaid payment, inpatient services must be in a general hospital setting. This means that a Mental Health Center, fully approved for Federal construction and staffing funds, will be denied Medicaid funds if it is not associated with a general hospital. The Medicaid patient requiring inpatient care would not be directed toward the Center, which offers a wide range of services whose very purpose is to discourage prolonged and expensive inpatient care. Instead, the patient would be sent to the general hospital—whose average daily cost is \$75, which might or might not be affiliated with a Mental Health Center whose average daily inpatient cost is \$33.

Moreover, the same situation exists for outpatient services. Outpatient services may be reimbursed by Medicaid if they are part of a Community Mental Health Center, but only if they are also a part of *hospital* outpatient services. The one exception is if the State Plan for Medicaid includes clinic services. In that case, outpatient services may be covered even though the outpatient services are not given through a hospital facility.

In commenting on this point, the study, *Financing Care of the Mentally Ill Under Medicare and Medicaid* stated:

"There are no national data on utilization by the States of Title XIX funds for support of community mental health services, although it is known that only 30 States and the District of Columbia, have taken advantage of the option to provide clinic services. The potential for use of community mental health services as an alternative to hospital inpatient care is suggested by the experience in one State where Medicaid payments for persons under treatment in community mental health centers have accounted for 5 to 60 percent of the income of the individual centers in the State. Indeed, the *Task Force on Medicaid and Related Programs* recognized the general need for broadening the availability of services in State Medicaid programs, recommending that:

"Innovative facilities for provision of medical care (e.g., neighborhood health centers, community health centers, group practices, outpatient services of hospitals which provide neighborhood, comprehensive ambulatory care and other facilities) should be included as eligible vendors which recipients under Title XIX may elect and be encouraged to use, assuming appropriate standards of health care are met.

"However, a comprehensive program of services for the mentally ill, with emphasis on ambulatory care, at present is not a requirement under Medicaid, and is not included in the Medicaid plans of a number of States."

A total of 452 Community Mental Health Centers has been funded. Of those, 300 are in full operation. An additional 118 will be funded by the 1972 budget just passed by Congress. It makes good sense for these Centers to become the "vendors" for Medicaid funds for both inpatient and outpatient services, regardless of whether or not they are hospital affiliated.

RECOMMENDATION

Therefore, NAMH recommends that community mental health centers be included among required vendors for Medicaid plans for both inpatient and ambulatory (outpatient, partial hospitalization, medications, etc.) services.

NEW DISCRIMINATION IN MEDICAID

It is distressing when we are bending every effort to end discrimination in various Social Security Amendments, to find new discrimination proposed in H.R. 1. In the description of an intermediate care facility, services provided to individuals under age 65 do not include services of any public institution for mental diseases or mental defects. The mentally retarded can qualify if: (a) primary purpose is to provide *health* or rehabilitation services; (b) if the patient is receiving active treatment.

The foregoing plainly points out that the discrimination is based not only on *age*, but also on *diagnosis*.

RECOMMENDATION

Therefore, NAMH recommends that H.R. 1 be amended to include intermediate care for the mentally ill under age 65 on the same basis as the mentally retarded.

CATASTROPHIC HEALTH INSURANCE

Mr. Chairman, we are well aware of your concern for people who are mentally ill. It was largely through your efforts that the Federal Government became a partner in sharing costs of care for indigent patients over 65 in mental hospitals. We are aware of your interest in providing similar coverage for children through age 21. We are also aware of your interest in a catastrophic health insurance program.

A substantial, though decreasing, proportion of the mentally ill persons requires prolonged treatment and care, long enough to become an economic catastrophe to their families.

We are, therefore, especially interested in the terms proposed for coverage and are frankly dismayed that the same top limits are proposed for mental illness coverage as in Medicare.

It seems quite illogical to us to label a program "catastrophic insurance" if, in addition to the substantial deductibles and co-insurance proposed to be taken off the bottom, there are also limits at the top. The net result might better be called trouble insurance, for, in effect, there is only a layer of coverage with the patient liable for payment both below and above. And, in the case of mental illness, unless our earlier recommendations are accepted, this layer is so thin as to be of little value.

RECOMMENDATION

We, therefore, recommend that there be neither co-insurance nor limitation on coverage of those few unfortunate people who become entitled to the benefits of Title XX.

INAPPROPRIATE USE OF MEDICAID FUNDS BY THE STATES

In some States, Medicaid funds have gone to the general treasury rather than into the State's mental health budget. We understand that several states are now in the process of developing legislation which would make it possible for Medicaid reimbursement for mental health service to be returned to the mental health program. To permit Medicaid dollars which were intended for the treatment of mental illness to be diverted into a State's general fund is inexcusable. Health monies should not be used to build highways.

RECOMMENDATION

Therefore, NAMH recommends that within one year of the enactment of these social security amendments, no Federal Medicaid monies for the treatment of mental illness shall be paid to States where those monies are diverted from such treatment. Even in those States where laws dictate that such monies must be received into general revenue funds, the State must show that appropriations for the State's mental health programs are increased by at least as much as the income from Medicare-Medicaid funds, plus any amounts attributable to general salary increases and other "cost of living" increments.

(SEPTEMBER 22, 1971.

The CHAIRMAN. The next witness will be Royce P. Noland, executive director of the American Physical Therapy Association.

STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR, AMERICAN PHYSICAL THERAPY ASSOCIATION, WASHINGTON, D.C.

Mr. NOLAND. Mr. Chairman, I am Royce Noland, executive director of the American Physical Therapy Association. The prepared statement of our association is before you. I request that it be made a part of the record of these hearings.

The CHAIRMAN. It will be.

Mr. NOLAND. My remarks will highlight this written statement which addresses itself to three major provisions:

H.R. 1 provides for the extension of medicare coverage to the totally disabled. We of our association fully support this logical expansion.

Section 241 provides that the Secretary will initiate a program of proficiency testing for certain health workers. We oppose this section not because we are opposed to the concept of proficiency testing but because we feel the section fails to provide adequate guidelines, constraints, and needed determination tests. I would refer you to the written statement for the details of our position on that matter.

Under section 251 of the bill there are two important provisions affecting physical therapy services for the beneficiaries. The first provides for the services of physical therapists in their outpatient center or at the patient's home. This is a much needed provision that will be of profound value to the beneficiaries, particularly those who are remote from hospitals or other private outpatient facilities. We strongly support this section.

Also under this same section 251 is another provision we refer to as the salary equivalency provision. We are offering substitute language for this section which is found on page 11 of my written statement. This provision is a cost containment approach. We acknowledge that there has been abuse or misuse of the program in some prior settings. We abhor this as much as anyone and support any reasonable cost mechanism.

Therefore, we are sympathetic to the concept of this provision. Basically it would use the cost of personnel employed by a provider as the basis to determine reasonable costs of personnel working under arrangement with the provider. Conceptually, it is simple; in application it is complex. We feel that the language needs to be amplified and clarified.

Our proposed alternate language is then only technical in nature. We feel that it will continue to the optimum and reasonable implementation of the rational intents of this provision.

In the main, our alternate language would (1) distinguish between full and part-time situations and give special consideration to the part-time situation; (2) it would instruct the comparisons for reasonableness of costs be between facilities of similar size, scope of service and utilization; (3) it would more clearly specify the overhead factors that would be recognized for reimbursement and, finally, (4) provide for recognition of productivity.

We make this last recommendation for we feel there is little value in controlling wages, salaries or any other means of compensation unless there is some measure of the amount of services being generated for this compensation whatever the form it might take.

We urge the committee to carefully consider and we hope adopt this substitute language.

In a draft intermediary letter by the Social Security Administration, the proposed, among other things, a formula to determine this equivalency feature as it appears in H.R. 1 using their formula and their figures, the following would be the result: If a person working by contract or under arrangement with a provider worked 52 weeks a year, did not take any vacation, was never sick, worked all holidays, Christmas and all, and assuming he had a sufficient patient load to stay fully occupied, he could earn up to but no more than the average salary of a staff physical therapist in a hospital. This is not a pipedream of ours; it was an actual proposal of the Social Security Administration. For this reason and for other concerns we have about the implementation of this section, we urge the adoption of our clarifying language so that reasonableness might be assured in the implementation of this otherwise very appropriate cost containment proposal.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, sir.

(The prepared statement of Mr. Noland follows:)

PREPARED STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR, AMERICAN
PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association represents over 18,000 qualified physical therapists in the United States. This constitutes well over 80 percent of the physical therapists in the country. Licensing acts prevail in all 50 states to govern qualifications, standards, and scope of practice.

The American Physical Therapy Association has been an active participant in advocating legislation and consulting on regulations for the purpose of advancing the availability of quality health care through comprehensive health care programs.

In a program of health care service such as Medicare, simple allusion to high quality comprehensive health care is insufficient and the promotion of this concept alone represents inadequate participation by any health profession or its representative association.

Neither is it adequate that the administrators of the program should see as the singular goal to merely arrange financial details, spend allotments, and reimburse vendors. If optimums are to be reached then there must be a collaboration between government agencies and the health professions so that continuous attention can be given to how the money is used and with what effects.

Every effort should be made to obtain as much effective health care as is possible from the resources that are available. It is to this end that we present the following testimony on H.R. 1, specifically in respect to additions and amendments to the provisions related to Medicare.

Much of the content of H.R. 1 was contained in similar legislation that was pending before the 91st Congress. Since this Association did present its view

before the Senate Finance Committee on that previous legislation, this statement will be directed to only three of the provisions of H.R. 1:

1. *Bill Section 102*, related to Coverage Under Medicare for Disability Beneficiaries.

2. *Bill Section 241*, Program for Determining Qualifications for Certain Health Care Personnel

3. *Bill Section 251*, relating to:

(a) (1) Inclusion of services of the physical therapist in his office or at the residence of the patient, and

(b) Limitation on payment for several health personnel via a salary equivalency method

BILL SECTION 201—COVERAGE FOR DISABILITY BENEFICIARIES

The physical therapist in his daily activity encounters persons afflicted with total disability. Because of this vantage point, the physical therapist acutely aware of the needs of these persons and the justice of extending benefits to them. Regardless of what other extensions might be made to the Medicare program, we can conceive of no other group more appropriate to add to this Medicare beneficiary group.

BILL SECTION 241—PROFICIENCY TESTING

The American Physical Therapy Association objects to inclusion of physical therapists in the "Program for Determining Qualifications for Certain Health Care Personnel" which H.R. 1 would require HEW to establish. The section would cover "practical nurses, therapists, laboratory technicians and technologists, x-ray technicians, psychiatric technicians, or other health care technicians," but not, registered nurses. It requires that "the Secretary . . . shall develop . . . and conduct . . . a program designed to determine the proficiency of individuals who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications . . ."

We presume this section was included in the bill because there are not enough academically qualified allied health workers in certain categories to meet all the needs of Medicare patients. Such a profound shortage does not exist in the field of physical therapy. There are more than 24,000 qualified physical therapists in the United States today, of which 18,000 are practicing their profession full or part time. With few exceptions this number is ample to meet the current demand for physical therapy for both Medicare and non-Medicare patients.

Our Association has taken substantial steps to assure that future physical therapy personnel needs will be met.

We feel that we must, at this point, state without qualification that the opposition of the APTA to this provision does not indicate that this profession seeks to protect its own vested interests. It is noteworthy that the American Physical Therapy Association was among the first of the allied health groups to pioneer development of paraprofessional assistants. The Association did this without a nickle of federal assistance and at a time when few professions were talking about "new types of allied health workers," as the press so fondly refers to them. In fact, there are at present 31 academic programs training physical therapist assistants. In addition, we are attempting to increase the number of schools producing physical therapists at the baccalaureate or postbaccalaureate level. There are now 59 schools, five of these having started in the last two years. The result of the combination of the two levels of schools will by 1973 double the number of physical therapy personnel being graduated each year.

It would seem obvious then, that the Association is concerned with upgrading the quality of service the patient ultimately receives and producing an adequate manpower supply of qualified personnel.

But we are concerned about the provision for another reason. In our estimation there does not exist today a formal method of gaging the proficiency of a physical therapist. The tests that do exist carry no guarantee that the person who passes the examination will practice with the same skill and knowledge as the physical therapist who has graduated from an accredited program.

While we grant that there are many things which physical therapists can learn to do and do well with on-the-job training, there are other areas of professional practice which today require more formal and scientifically based education.

For example:

A physical therapist is confronted with a middle-aged patient, paralyzed on one side as the result of a brain tumor which was successfully removed. The physician turns to the physical therapist to evaluate the extent of the paralysis, estimate the degree of return the patient can expect and design a rehabilitation program. But to make those judgments, the physical therapist must know something of neuroanatomy and neuropathology in order to understand the effect the tumor had on the central nervous system. Then the physical therapist must understand the complex nature of the muscle systems which permit normal functioning, that is, walking, sitting, and standing. As the patient progresses, the physical therapist must decide on changes in program, such as increasing the difficulty of exercises, or replacing the patient's long-leg brace with a short-leg brace. Each of these decisions is based on individual patient needs and no two patients are alike.

The disabilities of some patients require very accurate evaluations of muscle function. These tests are done (in addition to other methods) electrically by a method called electromyography. Although physicians performed these tests initially, more and more physical therapists are being trained in school to perform electromyography. This test can help the physician and the physical therapist differentiate nervous system diseases.

Training in these kinds of skill and knowledge levels can only be adequately accomplished through a course-work setting.

Thus, the lack of a formal background in anatomy, neuroanatomy, physiology, physics, or the function of muscle, could handicap a physical therapist in making independent judgments about the present state of a patient or his progress. Since there is no severe shortage of qualified physical therapists in the nation today, and because there are no guarantees that existing proficiency tests can accurately judge a physical therapist's qualifications, we do not think that the inclusion of physical therapy in the proficiency testing program required in H.R. 1 is worth the risk of lowered quality health care for patients—the ultimate beneficiaries of all our efforts.

BILL SECTION 251 (a) (1)—SERVICES BY INDIVIDUAL PHYSICAL THERAPISTS

The American Physical Therapy Association has long advocated the optimum utilization of all physical therapists under the Medicare program in accordance with the needs of the program. We are, therefore, most pleased to see this provision in the amendments now before the Congress. Inclusion of the proprietary physical therapist in the program will enhance the availability of services to the beneficiary group, have a positive effect on controlling costs, and make possible the optimum utilization of personnel and facilities within the community and give both the physician and the patient an optimum level of free choice of health personnel to utilize, without sacrificing quality of service or reasonable control of the services. For these reasons, the American Physical Therapy Association supports this section of the amendments.

We cannot, however, support the \$100 limitation imposed for this specific item. We would recognize the comfort that such a dollar figure ceiling may give an actuary, but we must also view optimum health care. The arbitrary termination of the treatment program in progress because of reaching a fixed dollar figure, does not seem congruous with the rest of the Medicare program. We strongly support, however, control mechanisms which will make not only the cost reasonable but the nature and duration of services appropriate to optimum health care.

An alternative to the \$100 ceiling would be to identify an arbitrary dollar figure (not necessarily \$100—perhaps more, perhaps less) and then specify that if additional care is to be reimbursed there must be a reevaluation of the patient's need for physical therapy and an identification of a specific program for continuation. This might occur via recertification by the physician, recertification by a utilization review body, or by consent of professional consultants within the offices of the fiscal intermediary.

BILL SECTION 251 (c)—SALARY EQUIVALENCY

Our Association has recognized that there has been in selected and isolated situations, misuse of the program either out of ignorance of intent of the scope for the program or in certain instances, apparent calculated effort to abuse the program. We deplore misuse regardless of the circumstances or motivation. We

recognize that the House Ways and Means Committee sharing our concern over misuse, real or potential and the increasing costs of the program, is seeking a device to bring about reasonableness in the cost for physical therapy services. We are sure that is the desire of the Finance Committee. We would concur in the concept of appropriate control mechanisms which would effectively bring about only reasonable charges for the service of physical therapy. It is our contention that the concept of trying to bring this about by arbitrarily equating to a "salary" level, is neither realistic nor will it be effective in bringing about the desired end.

Although we sympathize with the motivation for this amendment, we urge that it be altered and that the point of scrutiny to establish reasonableness of the cost be at the level primarily between the provided and the fiscal intermediary.

It must be recognized that the larger share of physical therapy services rendered under the auspices of a home health agency or in extended care facilities are rendered by physical therapists who are participating with the provider of service on a less than full time basis. Many of these physical therapists maintain treatment centers of their own. This implies overhead costs inherent in any type of professional practice and absence from their treatment center represents a need to be fiscally productive to the extent to meet costs of operation of their facility, plus a reasonable income for the practitioner. Salary equivalency, as described in this Section of H.R. 1, does not assure this.

We presume that the purpose of this section is to effect cost controls—not to regulate wages or income. It is in this context that we respond to this section. In this context we concur with the concept to wit: that two providers of similar size, scope of service, etc., should not have markedly different personnel costs, whether the personnel are employees of the provider or if the personnel are working under arrangement.

We contend that reasonable cost containment can be achieved, controls over abuse can be attained, and still reasonably accommodate the many and varied work situations in which physical therapists are needed.

A proposal to amend this Section of the bill is attached. It does not, however, represent a change in objective or thrust. It is, instead, a technical proposal to more equitably achieve the mutually desired end.

The APTA proposal would (in contrast to present H.R. 1 language) :

- (a) distinguish between full time and part time services in any given provider setting,
- (b) more clearly specify the overhead factors that would be recognized as part of the reasonable costs and,
- (c) provide for recognition of productivity,
- (d) instruct that when comparisons are made the facilities be of similar size, scope of service, and utilization.

The rationale for these proposals follow.

Just as it is not valid or reasonable to compare personnel costs (salaried personnel or otherwise) between facilities of dissimilar size or scope, neither is it valid to compare salary bases in institutions having full time personnel with the compensation level and methods for the less than full time situation. The uncertainties, the markedly varying patient load potentials, the need to maintain other treatment facilities and the absence of the normal expectation of longevity inherently make the less than full time situation one that lends itself to compensation methods and amounts dissimilar to employed compensation (i.e. salary or hourly rate). This is not to suggest the absence of reasonable control. Other third party payer programs such as intermediary private plans, state industrial schedules, and other governmental programs that have fixed allowable charge schedules could serve to establish reasonable "going rates" to assure that the reasonable cost concept could be protected.

Although the report of the House Ways and Means Committee is specific in the types of related expenses incurred by nonemployee physical therapists that would be reimbursable, the language of the bill is inadequate to insure congressional interest. For this reason that language has been strengthened and has been made more specific.

One of the principal advantages to the provider and third party payer of hiring personnel under arrangement is that the personnel costs be related to the personnel needs and that the program is not paying for personnel costs of unneeded personnel as will normally happen in the employed situation due to varying patient loads with relatively fixed personnel costs. This protection of the program should not be sacrificed. By making productivity a considerable factor, "value received"

can better be assured and the efficiency and proficiency of the nonemployee physical therapist will be stimulated. This is not intended as a measure of results but a determined "amount" of services. The simplest unit is a patient visit. The more complex is a relative value system. Any method used should distinguish between individual patient services, group treatment and the routine services of aides.

The data base necessary to establish the productivity quotient is easily discernible and is usually a routine part of the reporting records for Medicare, other third party payer programs and the Hospital Administration Services Reports (sponsored by AHA).

Physical therapy demonstrates one of the best manpower distribution pictures of any health profession. A major reason for this is the wide variety of employment relations that have been developed through the years to gain optimum utilization of the physical therapist in a number of situations and settings. The present H.R. 1 language would impair this distribution picture. We submit the following substitute language for the purpose of accomplishing the cost containment goals inherent in the H.R. 1 language but also to accommodate these various work situations so that this desirable manpower distribution and utilization picture will not be adversely effected.

APTA PROPOSED ALTERNATE LANGUAGE FOR SECTION 251, PARAGRAPH 5

(Present language is reproduced exactly, new language is underscored. Deleted language is shown in bold bracket:)

(5) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health related personnel (other than physicians) are furnished by a provider of services, or other organization specified in the first sentence of section 1861(p), or by others under an arrangement with such a provider or other organization, the amount included in any payment to such provider or organization under this title as the reasonable cost of such services shall not—

"(a) where such services are performed on a full-time basis or the equivalent of full-time basis exceed an amount [equal to the salary] which would reasonably have been the cost for such services [to the person performing them] if they had been performed in an employment relationship [with such provider or organization] (rather than under such arrangement) with a provider or organization of similar size, scope of services, and utilization, taking into account productivity plus the cost of such other expenses incurred by [such] a persons(s) not working as an employee, as the Secretary may in regulations determine to be appropriate,

or
"(b) where such services are not performed on a full-time or equivalent to a full-time basis, exceed an amount which would reasonably have been paid for such services to the person performing them taking into account productivity and the cost of other expenses such as maintaining an office and travel time incurred by such person not working as an employee, as the Secretary may in regulations determine to be appropriate."

The CHAIRMAN. The next witness will be Mrs. Florence Moore, executive director of the National Council for Homemaker-Home Health Aide Services, Inc.

STATEMENT OF FLORENCE MOORE, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.; ACCOMPANIED BY MISS PATRICIA GILROY, EXECUTIVE DIRECTOR, HOMEMAKER SERVICE OF THE NATIONAL CAPITAL AREA, WASHINGTON, D.C.

Mrs. MOORE. Thank you, Mr. Chairman. In the interest of time, I will read a portion of this testimony; however, I request that all of the written statement, including the attachment entitled "Whereas," appear in the record.

The CHAIRMAN. It will be.

Mrs. MOORE. My name is Mrs. Florence Moore. I am presenting this testimony in my capacity as executive director of the National Council for Homemaker-Home Health Aide Services, Inc., a nonprofit, tax-exempt organization, with offices at 1740 Broadway, New York, N.Y. I am accompanied by Miss Patricia Gilroy, executive director of the Homemaker Service of the National Capital Area, 815 Mount Vernon Place NW., Washington, D.C.

The National Council is a membership organization with a membership of over 300 agencies which provide homemaker-home health aide services. In addition, 50 health and welfare organizations, both State and National, 200 individuals, and several business and industrial corporations support the development of homemaker-home health aide services through an annual membership in the council.

The council's goal is availability in all sections of the Nation of homemaker-home health aide services to support individuals and families in their homes when there are disruptions to family life due to illness, disability, social disadvantage, or other problems, or where there is need of help in enhancing the quality of daily life.

Our goal in testifying is to discuss certain aspects of H.R. 1 which would have specific and far-reaching implications for homemaker-home health aide service if the bill were to be passed as it is written at present.

Homemaker-home health aide service helps families to remain together in their own homes when a health and/or a social problem strikes or helps individuals to return to their homes after specialized care. The homemaker-home health aide, as a member of the health and/or welfare team providing service in the home carries out assigned tasks in the family's place of residence, working under the supervision of a professional person who also assesses individually the need for the service and has responsibility for implementing the plan of care.

Some recent pertinent developments require special comment.

1. In the January 1969 and in the November 1970 issues of the Federal Register, the National Council for Homemaker-Home Health Aide Services was named by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, as a national standard-setting body for homemaker-home health aide services. Partly in response to this designation and with the active support and assistance of its members and other relevant national organizations, the council has developed and is implementing a national approval program which offers agencies throughout the country, whether under voluntary, governmental or proprietary auspices, help in assuring the quality of their homemaker-home health aide services.

2. The national council was invited by Dr. Arthur Flemming, chairman of the 1971 White House Conference on Aging, to plan a special concerns session on homemaker-home health aide services at this important decennial meeting. This session was held December 1, 1971. An account of this special concerns sessions appears in the White House Conference on Aging report. Most other sessions of the conference also stressed the need for the development and funding of this service to help the aging remain in or return to their own homes rather than be placed in costly institutions.

President Nixon, at the closing session of the conference, specifically states:

We can give special emphasis to services that will help people live decent and dignified lives in their own homes, services such as home-health aides, homemaker and nutritional services, home-delivered meals, transportation assistance.

As we testified recently before the House of Representatives Committee on Ways and Means, it is critical that a sound and broadly conceived plan for comprehensive home health services including homemaker-home health aide services, be a basic component of any national health insurance legislation.

Until such national health insurance materializes, the present programs must be improved. For example, Federal regulations relating to home health service, one of the covered benefits under medicare, have consistently been narrowed so that now far too few individuals can qualify for the service under medicare. It is essential that the narrow definitions and restrictive coverage plaguing the present home health service aspects of the medicare program be eliminated. Far from providing the promised help to the Nation's aged, medicare has been a source of frustration and dashed hopes that needed care would now be available where and when it was needed. The narrow definitions and the restrictive coverage have resulted in less than 1 percent of the national medicare expenditures being used to provide home health services.¹ Yet, the national council hears consistently from doctors, nurses, social workers, social service departments of hospitals, visiting nurse services, public welfare and public health departments, homemaker-home health aide agencies, and a host of other organizations that a service urgently needed to help people remain in or return to their own homes is homemaker-home health aide service. In fact, this need is so pressing that proprietary concerns have recognized it and are rapidly springing up throughout the country to make the service available to those who can pay for it on a profitmaking basis.

Medicare and medicaid programs should provide and pay for home health service, not only as an alternative to further hospital and nursing home care—although this is very important—but it must also provide for a comprehensive range of home health services for the neediest group of all, the chronically ill and aged. In England, with a population of almost 49 million people, some 71,000 homehelps—homemaker-home health aides—are employed primarily to provide service to the older chronically ill patients. In the United States, with a population of over 200 million people, there are less than half this number available to serve all the individuals and/or families who need them. Care at home should be available whether or not a patient has been in the hospital, if it is to serve the patient and community to its optimum extent from the standpoint of efficient service at a lower cost. Under the present law a part A beneficiary must be hospitalized before he is eligible for home health services which focuses the financial incentive on hospitalization. Under part B of medicare, prior hospitalization is not required. However, the regulations are so stringent under both part A and part B that few individuals can meet the qualifications. Allowing institutional care to continue to be the primary focus for Federal financial support of health care is highly unsatisfactory in terms of human costs and in terms of financial costs.

¹ Second Annual Report—Operation of Medicare Programs, January 20, 1969.

We commend the action taken in November 1970, when through regulations published in the Federal Register, the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, mandated that State plans must provide for homemaker service by April 1974 for those aged, blind, or disabled persons covered under titles I, X, XIV and XVI of the Social Security Act.

We urge that a similar mandate for all families with children who are in need of homemaker-home health aide service be promulgated whether through law or regulation. We recognize that in-home service has been mandated for children of families referred to and enrolled in the work incentive program, and for other persons for whom the agency has required training or employment. It should be mandated for all families requiring help in maintaining suitable homes for children.

We are pleased to note that homemaker service is specifically listed among the social service programs included in the language of H.R. 1.

The council's greatest concern with title IV of H.R. 1 involves the proposed limitations on open-ended appropriations for social services—except child care and family planning. A fixed appropriation would be devastating in its effect on the development of needed human services generally and on homemaker-home health aide service in particular.

Homemaker-home health aide service is now recognized as a basic health and welfare service which should exist in every community. It does not exist in many parts of the country, although it has been developing rapidly in recent years. This expansion has been accelerating as administrators, professionals, and others have begun to recognize the service's almost unlimited potential for strengthening family life, enabling children, aging individuals, the ill, and those with handicapping conditions to remain in or return to their own homes, and preventing that development of a wide variety of problems such as mental breakdown, juvenile delinquency, malnutrition, truancy, and absenteeism from work. There are only 30,000 homemaker-home health aides to serve all these categories of social and health needs. At a minimum, the people of the United States should have available 300,000 homemaker-home health aides.

A ceiling on Federal financing will retard the development of the service for the poor and near poor who have no means to pay for the service themselves. Existing programs will not be able to grow to meet demonstrated need, and in effect, the expansion of the service will be halted, just when it is on the brink of becoming a major positive force for the most natural resource any country can have—its people.

The CHAIRMAN. Incidentally, I might just interrupt you to state some of us are planning to use a lot of public service money we hope to make available to make jobs for working people, just put it in what you are talking about here, rather than paying people to sit home and do nothing, but qualify a lot of people to help provide services at home for sick people and that sort of thing who need those services, just as you have indicated in your statement. It is a very neglected area of services that should be provided to ill people especially the aged who can't get out.

Mrs. MOORE. Right. I might say some of our agencies have found

some splendid homemaker-home health aides from among the ranges of the welfare recipients.

1. Professional personnel is in short supply and it is expensive. Paraprofessional or allied professional help must be utilized where and when appropriate from the standpoint of safe and effective care. Homemaker-home health aide service is an exemplary utilization of the less expensively prepared individual;

2. All forms of social and health service, including homemaker-home health aide services, must meet basic standards of quality. The Council strongly endorses the concept of assuring quality services through utilization review and other standard-setting mechanisms, such as nationally recognized voluntary self-regulating programs including that established by the National Council for Homemaker-Home Health Aide Services;

3. To meet established national standards, homemaker-home health aides must be carefully selected, trained and supervised, but they do not require an extensive educational background. Therefore this vocation is proving to be a realistic choice for many educationally disadvantaged, but capable individuals. Often these are middle aged or older women and men. In many communities, homemaker-home health aides are recruited directly from families whose only source of available income has been public welfare. In some instances this source of employment has enabled the family to become self-supporting; in others, a minor amount of subsidization is still required. Growing numbers of agencies are developing career ladders and are providing job mobility for many such individuals. Many homemaker-home health aide agencies have part-time positions available which enables mothers to work during the hours their own children are in school. Thus the community stands to gain doubly from this service as previously unemployed individuals become self-sustaining.

4. Homemaker-home health aide services enable the "breadwinner" to retain or return to his or her job, knowing that the ill or dependent number(s) of the family is well cared for. Some 24 voluntary homemaker-home health aide agencies in New Jersey report, among other statistics, that in 1970 their services prevented 2,435 instances of absenteeism from work.

5. Homemaker-home health aide services are needed by rich and poor alike and must be available when and where they are needed. The community as a whole stands to gain from a physically and mentally healthy population as well as the individuals and families concerned. However, without the continuation of a secure funding base for the poor and near poor, agencies will not be able to develop the quality and quantity of services required throughout the Nation, even for those who can afford to pay for the service.

The National Council for Homemaker-Home Health Aide Services urges:

1. That open ended appropriations for all social services, and particularly for homemaker-home health aide services, be continued since the provision of these services is vital in helping individuals and families to maintain, or regain their independence and self-sufficiency so essential to a healthy society;

2. That homemaker-home health aide services be recognized along with child care and family planning as a major helping "tool" which

must continue to have the Federal assistance required to enable the needed expansion of the service;

3. That homemaker-home health aide service be specified as one of the integral parts of home health services in titles XVIII and XIX of the Social Security Act; and

4. That legislative mechanisms be developed to enable the formulation of regulations appropriate to meeting the needs for in-home social and health services of people throughout the Nation.

Thank you.

The CHAIRMAN. Thank you very much.

(Mrs. Moore's prepared statement with attachment follows. Hearing continued on page 2507.)

STATEMENT OF THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., PRESENTED BY FLORENCE MOORE

INTRODUCTION

My name is Mrs. Florence Moore. I am presenting this testimony in my capacity as Executive Director of the National Council for Homemaker-Home Health Aide Services, Inc., a non-profit, tax-exempt organization, with offices at 1740 Broadway, New York, N.Y. 10019. I am accompanied by Miss Patricia Gilroy, Executive Director of the Homemaker Service of the National Capital Area, 815 Mt. Vernon Place, N.W., Washington, D.C. 20001.

The National Council is a membership organization with a membership of over 300 agencies which provide homemaker-home health aide services. In addition, 50 health and welfare organizations, both state and national, two hundred individuals, and several business and industrial corporations support the development of homemaker-home health aide services through an annual membership in the Council.

The Council's goal is availability in all sections of the nation of homemaker-home health aide services to support individuals and families in their homes when there are disruptions to family life due to illness, disability, social disadvantage, or other problems, or where there is need of help in enhancing the quality of daily life.

PURPOSE IN TESTIFYING

Our goal in testifying is to discuss certain aspects of H.R. 1 which would have specific and far reaching implications for homemaker-home health aide service if the bill were to be passed as it is written at present.

DEFINITION OF SERVICE

Homemaker-home health aide service helps families to remain together in their own homes when a health and/or a social problem strikes or helps individuals to return to their homes after specialized care. The homemaker-home health aide, as a member of the health and/or welfare team providing service in the home carries out assigned tasks in the family's place of residence, working under the supervision of a professional person who also assesses individually the need for the service and has responsibility for implementing the plan of care.

RECENT DEVELOPMENTS

Some recent pertinent developments require special comment.

1. In the January 1969 and in the November 1970 issues of the *Federal Register*, the National Council for Homemaker-Home Health Aide Services was named by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, as a national standard-setting body for homemaker-home health aide services. Partly in response to this designation and with the active support and assistance of its members and other relevant national organizations, the Council has developed and is implementing a national approval program which offers agencies throughout the country, whether under voluntary, governmental or proprietary auspices, help in assuring the quality of their homemaker-home health aide services.

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President Nixon, at the closing session of the Conference, specifically states: "We can give special emphasis to services that will help people live decent and dignified lives in their own homes, services such as home-health aides, homemaker and nutritional services, home-delivered meals, transportation assistance."

TITLE II OF H.R. 1—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

As we testified recently before the House of Representatives Committee on Ways and Means, it is critical that a sound and broadly conceived plan for comprehensive home health services including homemaker-home health aide services, be a basic component of any national health insurance legislation.

Until such national health insurance materializes, the present programs must be improved. For example, Federal regulations relating to home health service, one of the covered benefits under Medicare, have consistently been narrowed so that now far too few individuals can qualify for the service under Medicare. It is essential that the narrow definitions and restrictive coverage plaguing the present home health service aspects of the Medicare program be eliminated. Far from providing the promised help to the nation's aged, Medicare has been a source of frustration and dashed hopes that needed care would now be available where and when it was needed.

The narrow definitions and the restrictive coverage have resulted in less than one percent of the national Medicare expenditures being used to provide home health services.¹ Yet, the National Council hears consistently from doctors, nurses, social workers, social service departments of hospitals, visiting nurse services, public welfare and public health departments, homemaker-home health aide agencies, and a host of other organizations that a service urgently needed to help people remain in or return to their own homes is homemaker-home health aide service. In fact, this need is so pressing that proprietary concerns have recognized it and are rapidly springing up throughout the country to make the service available to those who can pay for it on a profit making basis.

Medicare and Medicaid programs should provide and pay for home health service, not only as an alternative to further hospital and nursing home care—although this is very important—but it must also provide for a comprehensive range of home health services for the neediest group of all, the chronically ill and aged. In England, with a population of almost 49 million people, some 71,000 homehelps (homemaker-home health aides) are employed primarily to provide service to the older chronically ill patients. In the United States, with a population of over 200 million people, there are less than half this number available to serve all the individuals and/or families who need them. Care at home should be available *whether or not* a patient has been in the hospital, if it is to serve the patient and community to its optimum extent from the standpoint of efficient service at a lower cost. Under the present law a Part A beneficiary must be hospitalized before he is eligible for home health services which focuses the financial incentive on hospitalization. Under Part B of Medicare, prior hospitalization is not required. However, the regulations are so stringent under both Part A and Part B that few individuals can meet the qualifications. Allowing institutional care to continue to be the primary focus for Federal financial support of health care is highly unsatisfactory in terms of human costs and in terms of financial costs.

TITLE III ASSISTANCE FOR THE AGED, BLIND, AND DISABLED

We commend the action taken in November 1970, when through regulations published in the *Federal Register*, the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, mandated that state plans must provide for homemaker service by April 1974, for those aged, blind, or disabled persons covered under Titles I, X, XIV and XVI of the Social Security Act.

¹ *Second Annual Report—Operation of Medicare Programs*, January 20, 1969.

TITLE IV—THE FAMILY PROGRAMS—THE SOCIAL SERVICES PROGRAMS

We urge that a similar mandate for all families with children who are in need of homemaker-home health aide service be promulgated whether through law or regulation. We recognize that in-home service has been mandated for children of families referred to and enrolled in the Work Incentive Program, and for other persons for whom the agency has required training or employment. It should be mandated for *all* families requiring help in maintaining suitable homes for children.

We are pleased to note that homemaker service is specifically listed among the social service programs included in the language of H.R. 1.

The Council's greatest concern with Title IV of H.R. 1 involves the proposed limitations on open-ended appropriations for social services—except child care and family planning. A fixed appropriation would be devastating in its effect on the development of needed human services generally and on homemaker-home health aide service in particular.

Homemaker-home health aide service is now recognized as a basic health and welfare service which should exist in every community. It does not exist in many parts of the country, although it has been developing rapidly in recent years. This expansion has been accelerating as administrators, professionals and others have begun to recognize the service's almost unlimited potential for strengthening family life, enabling children, aging individuals, the ill, and those with handicapping conditions to remain in or return to their own homes, and preventing the development of a wide variety of problems such as mental breakdown, juvenile delinquency, malnutrition, truancy, and absenteeism from work. There are only 30,000 homemaker-home health aides to serve all these categories of social and health needs. At a minimum, the people of the United States should have available 300,000 homemaker-home health aides.

A ceiling on Federal financing will retard the development of the service for the poor and near poor who have no means to pay for the service themselves. Existing programs will not be able to grow to meet demonstrated need, and in effect, the expansion of the service will be halted, just when it is on the brink of becoming a major positive force for the most important natural resource any country can have—its people.

A few short examples are given to illustrate some of the ways in which this service helps individuals and families.

HOMEMAKER-HOME HEALTH AIDE SERVICE PROVIDES MOTHER SUBSTITUTE

When their twin boys were just five months old, Mrs. Smith had an operation for cancer. The doctor referred the family to the Cancer Society, saying the prognosis was extremely poor. Besides the twins the Smith's had three older children, and Mr. Smith, a city policeman, could think of no relatives who could assist him during this crisis.

A homemaker-home health aide was placed in the Smith home for eight hours, seven days a week. After six weeks this was changed to a six-hour day, five days a week, as Mr. Smith was able to secure baby-sitting services. Mrs. Smith was returned to the hospital a few months later and died. Mr. Smith had emergency surgery one week after his wife's death. Through these crises the homemaker-home health aide service was increased again and for about two weeks twenty-four-hour service was given. The Smith children were able to remain in their own home under the care of trusted and known "mother substitutes," while permanent plans for the family were being developed.

HOMEMAKER-HOME HEALTH AIDE SERVICE AIDS IN RAISING QUALITY OF FAMILY LIFE

Nine undisciplined children (ages 11 to 1½) and an unmotivated mother . . . referral by school due to offensive body odors . . . home found in complete disarray . . . no clean linen . . . fecal piles on floors . . . urine soiled cloths in bath tub and closets . . . bed bugs . . . inadequate refrigeration . . . grimy floors . . . lead poisoning . . . children appeased with candy when complaining of hunger . . . poor budgeting . . . immature disciplinary responses. Positive reaction during 24 weeks of instruction . . . (1) regular washing and ironing . . . (2) mother attending clinic . . . (3) budgeting allowed purchase of refrigerator . . . (4) extermination accomplished . . . (5) family began to eat at table . . . (6) minimal control of bed-wetting . . . (7) school attendance improved . . . (8) mother keeping children on schedule of duties . . . (9) children developed pride in personal appearance . . . (10) mother attended group sessions regularly . . . (11) mother aware of defi-

ciencies in disciplining . . . (12) desiring to be more effective . . . (13) referred to public agency for continuation of instruction.

HOMEMAKER-HOME HEALTH AIDE SERVICE ENABLES AN AGING PERSON TO RETURN HOME

Mrs. Schmidt, 79 years old, went to a nursing home upon the advice of her physician, but was extremely unhappy and returned to her own home. Referred to the home health agency by the doctor, Mrs. Schmidt was maintained at home under an appropriate plan with a homemaker-home health aide assisting with personal care, shopping, meal preparation and light housekeeping on a four-hour, three-day a week basis.

OTHER IMPORTANT POINTS

Several points which must not be overlooked in this discussion include the following:

1. Professional personnel is in short supply and it is expensive. Paraprofessional or allied professional help must be utilized where and when appropriate from the standpoint of safe and effective care. Homemaker-home health aide service is an exemplary utilization of the less expensively prepared individual;

2. All forms of social and health service, including homemaker-home health aide services, must meet basic standards of quality. The Council strongly endorses the concept of assuring quality services through utilization review and other standard-setting mechanisms, such as nationally recognized voluntary self-regulating programs including that established by the National Council for Homemaker-Home Health Aide Services;

3. To meet established national standards, homemaker-home health aides must be carefully selected, trained and supervised, but they do not require an extensive educational background. Therefore this vocation is proving to be a realistic choice for many educationally disadvantaged but capable individuals. Often these are middle-aged or older women and men. In many communities, homemaker-home health aides are recruited directly from families whose only source of available income has been public welfare. In some instances this source of employment has enabled the family to become self-supporting; in others, a minor amount of subsidization is still required. Growing numbers of agencies are developing career ladders and are providing job mobility for many such individuals. Many homemaker-home health aide agencies have part-time positions available which enables mothers to work during the hours their own children are in school. Thus the community stands to gain doubly from this service as previously unemployed individuals become self-sustaining.

4. Homemaker-home health aide services enable the "breadwinner" to retain or return to his or her job, knowing that the ill or dependent member(s) of the family is well cared for. Some 24 voluntary homemaker-home health aide agencies in New Jersey report, among other statistics, that in 1970 their services prevented 2,435 instances of absenteeism from work.

5. Homemaker-home health aide services are needed by rich and poor alike and must be available when and where they are needed. The community as a whole stands to gain from a physically and mentally healthy population as well as the individuals and families concerned. However, without the continuation of a secure funding base for the poor and near poor, agencies will not be able to develop the quality and quantity of services required throughout the nation, even for those who can afford to pay for the service.

SUMMARY

The National Council for Homemaker-Home Health Aide Services urges:

1. That open ended appropriations for all social services, and particularly for homemaker-home health aide services, be continued since the provision of these services is vital in helping individuals and families to maintain, or regain their independence and self sufficiency so essential to a healthy society;

2. *The homemaker-home health aide services be recognized along with child care and family planning as a major helping "tool" which must continue to have the Federal assistance required to enable the needed expansion of the service;*

3. That homemaker-home health aide service be specified as one of the integral parts of home health services in Titles XVIII and XIX of the Social Security Act; and

4. That legislative mechanisms be developed to enable the formulation of regulations appropriate to meeting the needs for in-home social and health services of people throughout the nation.

Whereas...

... it is generally recognized that the best and most desired place for children and adults to live is in their own homes; and,

... it is known that a home once broken is much more difficult to re-establish; and,

... it has been found that thousands of individuals of all ages could remain in their own homes or return to their own homes from foster care or institutional care if suitable in-home care were available; and,

... individuals recover more quickly in familiar and supportive surroundings when care at home is the appropriate choice of services; and,

... care at home in many instances is an economical alternative to out-of-home care; and,

... comprehensive health and welfare services delivered in the home are required to meet human need and support family life and homemaker-home health aide services are an important part of such services; and,

... appropriate use of homemaker-home health aide services in conjunction with other needed services may prevent physical, emotional or social breakdown where individuals or families are severely disorganized or under extreme stress; and,

... homemaker-home health aide services are frequently sought and needed by rich and poor alike, though the services are still in short supply; and,

... the use of homemaker-home health aides facilitates better utilization of professional manpower; and,

... homemaker-home health aide services offer employment and career ladder opportunities to thousands of capable women and men; and,

... homemaker-home health aide services should be available to any person irrespective of race, creed, color, national origin, income level, or where an individual or family is located when they are needed and are a sound, desired, and responsible plan.

THE GOAL . . .

The goal of the National Council for Homemaker-Home Health Aide Services is availability in all sections of the nation of homemaker-home health aide services in the home to support individuals and the family when there are disruptions due to illness, disability, social disadvantage, or other problems, or where there is need of help in enhancing the quality of daily life.

HOW TO ACHIEVE IT . . .

Standards

The National Council for Homemaker-Home Health Aide Services believes that such services may be provided by either a health or a social service agency, under public auspices, a non-profit voluntary agency, or a proprietary agency. Whatever the agency auspice, they must meet basic standards set by a responsible national agency, with appropriate machinery for the enforcement of the standards. Wherever possible, state and local standards should exceed the level feasible for basic national standards.

Service

Homemaker-home health aide services should be used to prevent family breakdown, to maintain individuals and families in their own homes, and as an adjunct to preventive, rehabilitative and treatment services and/or as the treatment service of choice.

The services are flexible in meeting a wide range of needs. They are effective in strengthening the use of many other health and welfare services, such as day care, consumer education, and out-patient treatment of both physical and psychiatric conditions.

Service (Con'd)

Homemaker-home health aide services, whether offered by a social welfare or a health agency, are a team service involving both professional and allied staff.

People have the right to remain in their own homes if that is their choice and if a desirable plan can be made. Homemaker-home health aide services should be continued so long as they are the appropriate type of care.

Support

Funds from non-governmental sources as well as funds from state and local governmental sources are required.

Also, there must be federal funding, on a generous matching basis, with receipt of the needed service not conditional upon receipt of any other health or welfare service. Such federal funding should be available without a fixed ceiling.

Rates for such services should be set on the basis of inclusive reasonable cost. Services should be free to all who meet customary income tests for health or welfare services. Other individuals or families should be able to purchase care based on their ability to pay.

Agencies may provide the service directly or make the service available through contract with other agencies where this arrangement meets the needs of a given community.

HOMEMAKER-HOME HEALTH AIDE SERVICE

A Definition

The service goes by a variety of names, but whether it is called "homemaker service," "home health aide service," or "homemaker-home health aide service," it is an in-home service under the auspices of a public agency or non-profit voluntary health or welfare agency or a proprietary agency.

Providers of the service include visiting nurse associations and other home health agencies, local welfare departments, and other family and child welfare service organizations under various auspices.

Some provide homemaker service as their only service; others provide it for just one age group or problem group such as for the aged, children, or the sick. Still others serve a wider range of clientele or problem categories.

In any event, qualified persons employed, trained and supervised by local agencies are assigned to work with individuals or families as needed, such as in care for the young and the old, the sick, the mentally ill, the retarded, the disabled, or the disadvantaged. The need for homemaker-home health aide service is determined by a professional person who functions as an essential part of the service.

This service helps individuals to maintain themselves in their homes and, as appropriate, to strengthen their functioning and raise the quality and level of their daily living.

Homemaker-home health aides work under the supervision of a social worker, a nurse, or another member of the professional team responsible for helping to resolve the problem that made the service necessary in a particular home.

HOMEMAKER-HOME HEALTH AIDE

A Definition

A homemaker-home health aide is a trained, supervised person who works as a full-fledged member of a team of professional and allied workers providing health and/or social services.

The homemaker-home health aide is employed as a staff member of an agency to which she is accountable for her performance. The homemaker-home health aide is assigned to work in the home of an individual or family when home life is disrupted by illness, disability or social disadvantage or when the family or individuals within the family are in danger of physical, social or emotional breakdown because of disorganization or stress with which they are unable to cope effectively. The homemaker-home health aide may also be assigned to work with groups whose members are in need of help in raising the quality of their home life.

The nature of the work of the homemaker-home health aide is practical, psychological, and educational. Under professional supervision of a nurse, social worker, or other appropriate professional, she gives needed care to children and families, to the aged, to the chronically ill, to persons convalescing at home, to the physically handicapped, to the mentally ill, and to those who are socially incapacitated.

Among many ways appropriate care may be given are the following: care for children during the absence or incapacity of the parent; performing or helping to perform household duties — marketing, preparing meals, cleaning the house and doing the laundry; providing personal care such as giving a bed bath, helping the patient with prescribed exercise or reporting to the professional health supervisor changes in the patient's condition; teaching through demonstration and practical suggestions how to care for children, the value of and how to prepare nutritious meals, how to budget, how to market and how to organize a household; providing emotional support and understanding; observing strengths and weaknesses in individual and family functioning to assist the professional members of the team to make an adequate plan.

Through such service the homemaker-home health aide helps individuals and families to sustain, attain or regain their abilities to maintain themselves in their own homes and to enhance the quality of their daily life.

The CHAIRMAN. We had not previously scheduled but we have had requests to hear from the National Federation of Social Service Employees and 37 organizations. Is Ozzie Edwards here?

STATEMENT OF OZZIE EDWARDS, NATIONAL FEDERATION OF SOCIAL SERVICE EMPLOYEES AND AFFILIATED ORGANIZATIONS

Mr. EDWARDS. Mr. Chairman, I came without a prepared text because of our feelings that are emanating from people all over the country in reference to the consideration of legislation of H.R. 1 welfare reform that will destroy the family unity throughout this country.

I didn't prepare a text that talked about the adverse effects to FAP, at the excuse that we are against liberalized benefits for our senior citizens and the aged. We are but to sacrifice the old and the children with the hidden myth that our welfare mothers and fathers do not want to work and are on the lowest totem pole, Mr. Chairman, I vehemently object to this classification.

We feel that our mothers throughout this country are doing a job by raising their children and that there is no question of illegitimacy for every child is legitimate.

We question a guaranteed floor of \$2,400 for a family of four, taking away from the northern States and giving it to the southern States that refuse to come up to minimum levels of payments for their own constituents. Mr. Chairman, we question the exclusion of the food stamps. We question Senator Talmadge's amendments of forced slavery making people accept jobs without entry level, upward mobility, relevant training and promotional opportunity. Mr. Chairman, we question that.

We are concerned for we feel that when the citizenry is knowledgeable of the points, the citizenry will react, and people know that your bill that you are considering is not for the good of the poor of this country. Mr. Chairman, we question that.

Second, in the area of the nonexclusion of the parents rights in a legal matter, that is, if a family's check is taken away it can be given to somebody outside of the family, a third party vendor payment, Mr. Chairman, we question that. May I reiterate a point that we did in Haynesville, Ala., where a welfare mother's check was given to a white lady who took the check and paid for the food for those children but she worked as a maid in that lady's kitchen. Vendor payment, we question that.

We didn't come before this committee to talk about the employment rights. We know that the concern is not for the workers. We know that. We know that in Washington, D.C. this weekend, parents from 40 States and child care advocates questioned your child development cooperation with nonparental involvement. Mr. Chairman, we question that.

And I shall conclude, for I didn't come here to be rhetorical and I would beg that this Committee would let me submit a written, academic intellectual report of how we do feel. However, I would like to move from this podium and talk to a parent, Mrs. Joyce Kursman, who can

tell you how she feels about what you plan to do to the children of this country. [Applause.]

The CHAIRMAN. It is against the rules of this Committee to conduct a demonstration and we would like to ask you to not to engage in demonstrations or applause or booing or anything of that sort through the testimony of the witnesses. Go ahead.

Mrs. KURSMAN. I have been asked by the parents represented here in Washington representing over 40 States in the United States to speak. I have not come with any prepared speech but, Mr. Chairman, I am going to speak as a parent of a child, of three children, I am going to speak as a parent representing 10.5 million children in these United States of America, who do not have comprehensive child care benefits as are necessary to our children.

Our children for a long time have been the point of legislation, of ridicule, of all kind of stuff, OK, I can't get the words together but I think, Mr. Chairman, you know what I am coming to. We are tired of having our children used as distrust, political pieces of a chessboard, if you will.

Mr. Chairman, our children are people. We are people, and as people of this United States it is time that you, Mr. Chairman, and the Congress of these United States started listening to us, started hearing what we want for our children. We want our children, who are the poor children through no fault of their own, and through no fault of ours as mothers of those children, to have equal rights and benefits as do other children in these United States. Because they come from poor families, families with troubles, they should not be prejudiced against. H.R. 1 is a discriminatory piece of legislation. Mr. Chairman, it is a slap in the face of the intelligence, the intelligence, sir, of these parents of these United States. We have done our homework, sir. We have got ourselves together, and we know where H.R. 1 is coming from and it ain't coming from the people and it ain't for the people.

How can it be for the people when it talks about an income of \$2,700. The income now, instead of \$3,950 which is not even realistic, this \$2,700 wage level represents only three-fourths of the minimum wage. Under H.R. 1 they don't even want to give us food stamps. They have already been taken away from so many parents, families. Some States have been cut to such a minimum they can't worry about housing. They are being put out on the street because instead of paying the rent they are worrying about feeding their children. They are worrying about putting some clothes on their backs.

We are not asking to live in palaces. We are not asking to have caviar and steak and lobster like some of you in Washington do, at our expenses, because as poor as we are, every time we walk into a store we are paying our taxes.

I come from the State of New Jersey and I pay tax to say good morning to my neighbor, in a sense.

We may, some families collect welfare and I am tired of people saying "we are giving that to you." Mr. Chairman, the families who are on welfare, as I previously stated, are not there because this is their choice. They have children who they are concerned for and they don't want to be there. They want to get themselves together and get off, and that is going to be our objective.

But in the meantime are we to sacrifice the children, our children, at the expense of a piece of worthless legislation, a piece of legislation that cuts and demoralizes the people and parents and children of the country. I am tired of my child and these people of these U.S. children, of the poor being used for some political football.

Mr. Chairman, if I sound excited, it is because I am. I have come to conference after conference, I have fought at my city level, at my county level, my State level and now we got ourselves together at a national level and we are becoming to move in full force as we have been doing today and the last week against this H.R. 1 bill. We have been to see our Senators and our Congressmen, letting them know how we feel, but you, Mr. Long, Mr. Chairman, you have got to listen to us. We parents have got ourselves together, we know where this thing is coming from. A mother, with a child 3 years old, telling her she has got to go to work for a wage of \$1.20 an hour. Mr. Chairman, Lincoln freed the slaves, some 150 years ago. We ain't going back to that, and this is what this is.

A mother who has children on welfare should have a choice just like anybody else in this country to decide what kind of work she wants. It should not be necessary for her to sign and be given a job and if she refuses that job at that fee of \$1.20 an hour she will lose her grant. This should not be necessary, Mr. Chairman. The opportunity under H.R. 1 for parents is nil. There is nothing there for the parents. OK. They have nothing to say about the care that is going to be given to the children. You talk about socialism. This is socialism, Mr. Chairman, putting my child in a day care center, not getting any educational benefits, just having a babysitter waiting on him. What is this child going to benefit. When he comes to the public school system, and keep in mind, Mr. Chairman, as you know, I am sure you know, that several of our States do not have kindergartens so we are putting our children right into first grade, OK. A lot of school systems have kindergartens so they can get themselves together a little bit. Our day care services as they are now give our children this educational readiness that is needed because they have been oppressed too long, because they have lived in the ghettos, in the filth and the dirt and not been given the opportunity to get what they need, so that when they are in school and when they put their foot in that schoolroom they are together equal with the other children at school, equal in education, equal in health, welfare of those children, equal and together.

Mr. Chairman, I as a parent representing these parents, am vehemently opposed to H.R. 1. There is not one iota in it that we can deal with, and we ask, we implore this Committee, don't deal with this because you are wasting time. It is just a waste of time, because our parents, registered voters throughout the United States, are getting themselves together, and it is not going to get—it is not going to go any place, so you are wasting your time dealing with this kind of legislation.

I think I have covered the main aspects. I thank you, Mr. Chairman, we were not on your agenda but I just want to reiterate one more time without being repetitious, Mr. Chairman, on behalf of 10.5 million children, please, for God's sake hear us. Thank you. [Applause.]

THE CHAIRMAN. Thank you very much. Thank you for your testimony. The Committee will meet at 10 o'clock tomorrow.

Mr. EDWARDS. I have one more thing to say as you pass. I know you have got to vote but these people came from 40 States and as that parent said the thing is coming, you can't divide us anymore on the race issue, it is colorless. Before you open the door despite what you do, and you are not going to pass anything out of this committee because as you are, you are against the children, there is a plan in this country that our children are going to eat and you are going to feed us. [Applause.]

(Whereupon, at 1:10 p.m. the hearing was recessed to reconvene Tuesday, February 8, 1972, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1971

TUESDAY, FEBRUARY 8, 1972

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10:00 a.m., in room 2221, New Senate Office Building, Senator Herman E. Talmadge presiding.

Present: Senators Long (Chairman), Anderson, Talmadge, Nelson, Bennett, Curtis, and Jordan of Idaho.

Also present: Representative Clark of Pennsylvania.

Senator TALMADGE. The committee will please come to order.

It gives me great pleasure this morning to welcome as the first witness before our committee Dr. F. William Dowda, who is a warm friend and a valued constituent.

Dr. Dowda has had an outstanding career as a practicing physician. He was a diplomate of the American Board of Internal Medicine, a member of the recently established National Institute of Medicine. He is presently president of the Georgia Medical Care Foundation and president-elect of the Medical Association of Georgia.

I have had many conversations and visits with Dr. Dowda over a period of several years and I know of his deep interest in trying to make medical care available for all the people of this country at the cheapest possible cost to the taxpayers of America.

Accompanying Dr. Dowda today is Mr. James E. Bryan, who is the Washington representative of the American Association of Foundations for Medical Care.

Bill, we welcome you to the committee. We are delighted to have you, and you may proceed as you see fit.

STATEMENT OF F. WILLIAM DOWDA, M.D., SECRETARY AND MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE; ACCOMPANIED BY JAMES BRYAN, CONSULTANT, WASHINGTON REPRESENTATIVE, AAFMC

Dr. Dowda. Thank you, sir.

Mr. Chairman and members of the Senate Finance Committee, I am honored to have the opportunity of appearing before you this morning. I appreciate the recitation, Senator, of my qualifications to appear before you as a practicing physician, and my basic position here this morning is to support Senator Bennett's amendment to H.R. 1 to establish professional services review organizations throughout the United States. This was submitted to the Senate on January 25, 1972.

I do have with me this morning Mr. James Bryan who is our consultant in medical care administration and the Washington representative of the American Association of Foundations for Medical Care.

We of the American Association of Foundations are gratified to find in your committee release No. 66 of September 30, 1970, and recently reiterated by Senator Bennett the statement that if his amendment becomes law, "organizations representing substantial numbers of physicians in an area, such as medical foundations and medical societies, would be invited and encouraged to submit plans meeting the requirements of the programs."

We assure you that members of our national association will take whatever practicable steps may be required by this legislation to qualify for recognition and to serve as PSRO's in their respective areas of operation.

We emphatically commend the continued effort of Senator Bennett which we hope will again be endorsed by the members of this distinguished committee and also hope the Senate as a whole endorses efforts to encourage the effective review mechanism whereby, to use Senator Bennett's words, "practicing physicians can, in organized and publicly accountable fashion determine on a comprehensive and on-going basis if services are medically necessary and if they meet quality standards."

In presenting this amendment to the Senate on January 25 last, Senator Bennett generously cited the efforts of foundations in New Mexico, Colorado, and our own State of Georgia to effectuate the PSRO concept, and he stated a basic principle that we strongly believe in, that "only physicians are capable of deciding whether a service is medically necessary or meets proper quality standards. Therefore, peer review must mean just that—only physicians should review physicians." A pervasive sophisticated peer review program is the very heart of the foundation function.

At the same time, we concur with Senator Bennett's further statement that if his amendment becomes law, "the Government, the public, and the professions can and should audit the review process itself to determine what review activities are occurring. Additionally,"—as Senator Bennett points out—"we, the public, can and should review aggregate statistics from each review organization in order to determine the overall effectiveness of the review process." Foundations for medical care are firmly committed to the necessity of strong public participation in determining the scope, cost and availability of service and in helping to shape the future of our medical care delivery systems.

There has been some comment about—the worry about—turning the folks loose in the henhouse and I think with this in mind I am sure this is going to come up, that it might be helpful at this point to summarize recent foundation experiences in three areas. These are New Mexico, Georgia, and San Joaquin County, Calif. I talked with Dr. John Wood of the Colorado Foundation yesterday before coming here and his experience generally goes along with those of these three areas, so I will limit my comments to these three States.

Dr. George Boyden, president of the New Mexico Foundation, informs us that preliminary estimates indicate that the New Mexico medicaid program is becoming cost-effective and will probably stay

within its budget this year for the first time since the inception of the medicaid program in New Mexico. I think this is an extremely important and critical statement.

Dr. Boyden also reports that the most impressive factor in this brief 5-month period has been the extremely effective work of hospital utilization review committees in the New Mexico foundation's hospital admission precertification program. Both through this hospital utilization review activity and through claims review, Dr. Boyden reports that education of the reviewing physicians themselves has been an unanticipated side benefit.

In California, a UCLA study of a pilot prepayment program for medicaid, conducted by the San Joaquin Foundation for Medical Care, utilizing peer review, reaffirms the results of Dr. Boyden's study. It is clearly demonstrated that more patients were seen at a lower total cost than in the nearby control county of Ventura. For the same dollar benefit, the San Joaquin medicaid patients also received more preventive services, such as immunizations, consultations and outpatient diagnostic and therapeutic services than were delivered in the control county.

Our foundation's immediate medicaid activities in Georgia parallel and confirm the findings reported in New Mexico and California. Our impact has also been registered in the field of nursing home services where expenditures are down 15 percent from this time last year. When this report was prepared last week, I did not have the action of the Senate Subcommittee on Budget of the State of Georgia. It has subsequently acted and the Senate Appropriations Committee has cut from the medicaid budget for this current fiscal year \$3.5 million. This is from the Georgia budget alone. If one adds the Federal matching funds this results in a savings on the medicaid program for the current year that is occurring of approximately \$12 million.

Senator TALMADGE. Will you yield at that point, Dr. Dowda?

Dr. DOWDA. Yes, sir.

Senator TALMADGE. I presume Georgia would be about the average State; Georgia is about average size in population. If we multiplied that by 50 States we are talking about a savings of \$600 million.

Dr. DOWDA. Actually, Georgia has a population in excess of 4 million people and we have approximately 400,000 on medicaid.

Our calculations would be somewhat in the neighborhood of \$1 billion.

Senator TALMADGE. \$1 billion?

Dr. DOWDA. Yes, sir.

Senator TALMADGE. Do you attribute all that saving to peer review?

Dr. DOWDA. Yes, sir; very frankly, I do. At this time last year at exactly the same point in the budget we had expended 82 percent of approximately all funds in the medicaid budget and it was only 6 months old. This year, in reviewing what our expenditures have been, we only have expended 27 percent of the budget and it is still 6 months old. The difference has been we feel in the peer review that the physicians of Georgia have been doing in this intervening period of time.

Senator TALMADGE. It is a remarkable success story and I congratulate you.

Dr. DOWDA. Thank you, sir.

Added to this, during the past year we have been adding 5,000 medicaid recipients per month to the rolls that we already have; so what we have is a decreasing budget with an increasing population of medicaid recipients.

We feel that all of this has been done without any sacrifice in quality. In fact, we believe that the quality has improved and, in cooperation with the regional medical program, the foundation and the medical association of Georgia are working to solve the problems of accessibility and acceptability into the medical care system. This has been done largely in our State by the development of access stations. These access stations provide paramedical and skilled nursing care such as nurses and physicians' assistants who can provide emergency first aid, cardiopulmonary resuscitation, and also arranging for triage and transportation. So we feel the medicaid recipients and other patients in the State of Georgia are getting a new entry into the health care system.

The basic objectives of the foundation for medical care are precisely as are those of the PSRO and that is (1) to monitor the quality of care provided by community physicians on a continuing basis; (2) ascertain that each medical service is rendered in the most appropriate and least expensive setting; (3) help assure that the scope of care rendered each patient is sufficient to his need, but not excessive.

Beyond these objectives of PSRO, foundations concern themselves with a determination that the price of medical service, whomever rendered, is reasonable.

But the essence of the foundation's contribution to modern medicine is its revolutionary effect on the educational processes of medicine. The physician's relationship to the foundation permits him to take full advantage of the health care delivery opportunities which his community and scientific advances offer him, without fear of recriminatory liability.

It seems apparent the PSRO has already been convincingly demonstrated by foundations for medical care. Here, in self-contained communities of manageable size, the medical profession has accepted and has learned how to discharge a collective responsibility for providing comprehensive medical services at predictable costs to the individual or the group contracting for service.

Participating physicians have vested their representatives in the foundation structure with the power to contract for provision of their services and to monitor and evaluate these services when rendered. Physicians themselves, on the broadest scale, are encouraged to participate in the evaluation processes. Through the foundation mechanism, solo physicians thus achieve for themselves and their patients the factors of quality control and efficiency that are usually attributed to group medical practice. In effect, the foundation for medical care functions as a clinic without walls. It has the added flexibility of being able to care for rural as well as urban populations.

The experience of our more mature foundations has already demonstrated that they are able to carry out the function described in this amendment with respect both to post facto review of services rendered and to the prospective evaluation of elective or nonemergent medical services.

We are prepared to support the maintenance of high standards for qualification of foundations for designation as PSRO units, recognizing that creditable performance by each foundation will enhance the standing of all of them and, conversely, that inadequate performance by any tends to discredit all.

We also strongly approve the provision in section 1169 of technical assistance for organizations having a "potential for meeting the requirements of a PSRO," and the provision, in section 1170, of aid for PSRO's wishing to test or demonstrate their ability to "assume responsibility and to assume risk with respect to the review and payment of claims for health care services."

The foundation for medical care movement originated in California 18 years ago and in recent years has spread to more than 30 other States. Each month brings news of additional areas into the foundation fold.

These foundations grow out of a recognition by the medical profession that it is vitally challenged to put its own house in order and to demonstrate its ability to monitor, to evaluate and to assure the the highest possible quality of professional performance by each individual physician.

The development of foundations for medical care and their hoped-for recognition and encouragement by the Federal Government, through the Bennett amendment, will bring the medical profession and Government together in a practical working relationship that is essential to the success of any future program for health insurance whatever its nature and scope may be. This legislation will help to break down the continuing lack of mutual trust and cooperation which has kept so many Federal medical care programs from operating with real efficiency and satisfaction, not only to the patient and the doctor but also the Government as well. It will help progressive medical leaders to mobilize the great potentials that lie within the medical profession for responsible and effective community service.

On behalf of the American Association of Foundations for Medical Care, I wish to thank you, Mr. Chairman, and all of you gentlemen, for the opportunity of presenting this testimony.

Senator BENNETT. Mr. Chairman, I obviously would like to take this opportunity to thank Dr. Dowda and his associate for this testimony. It is heartening, after 2 years of fighting, to realize that the PVRO program and its potential is being understood. There was very properly a lot of misunderstanding and a lot of questions about the program when it was introduced and we who introduced it have learned a lot in the 2 years and if you compare the text of the amendment that is offered to this bill to the original text offered 2 years ago, you will see how we have tried to adjust the ideal to fit the realities of the situation, not only as it involves doctors but also hospitals and other providers of health services.

I am not sure it is perfect now but it is very heartening to know that there are those in the country, and I dare hope that the majority of the organizations in the medical profession in the country are coming to realize the necessity for this kind of a mechanism and realize that we are trying to develop the most effective mechanism; and I am happy to know that in New Mexico and in Georgia the mechanism is working as well as it is.

Senator TALMADGE. Doctor, I want to congratulate you on your statement. My recollection is that the Medical Association of Georgia was one of the first States, if not the first State, Georgia Medical Association, to endorse the peer review idea; was that not correct?

Dr. DOWDA. That is correct, sir.

Senator TALMADGE. I addressed a medical group in Boston a year ago and I found at that time there was considerable diversity of opinion among the medical profession about the desirability of having peer review.

Do you still have that diversity of opinion or is it overwhelmingly in favor of peer review at the present time?

Dr. DOWDA. As you know, actually, almost 20 States now have publicly gone on record as endorsing Senator Bennett's amendment—their State medical association.

I find actually as we attend meetings of the American Medical Association that almost uniformly that physicians are in favor of peer review and feel that it should be done in the method as described in Senator Bennett's amendments.

Senator TALMADGE. I found some objection to it in some quarters before they fully understood it. Once they understood the facts, I found overwhelming support for it. Is that about what you have concluded?

Dr. DOWDA. Yes, sir.

Senator TALMADGE. Thank you very much. No further questions, Mr. Chairman.

The CHAIRMAN (presiding). Doctor, I want to congratulate you on your very fine statement. You have perceived what was obvious to me from the beginning, that Senator Bennett was trying to do something that would be in the best interests of the medical profession, as well as in the best interests of the Government and the citizens.

I find it difficult to believe anyone could believe that with his credentials, Senator Bennett would be sincerely sponsoring something that would undermine or do any violence to the high ethical principles of the medical profession; and I am happy to see that doctors such as yourself have studied this matter impartially and found its merits and rallied to its support.

Thank you for your statement.

Dr. DOWDA. Thank you very much, sir.

The CHAIRMAN. Our next witness will be Mr. Warren W. Simonds and Mr. Charles R. Gage, on behalf of the Louisiana Hospital Association.

Mr. SIMONDS. Thank you, Mr. Chairman.

The CHAIRMAN. I am not sure whether it would increase your standing with your associates in the hospital association to know that you and I were classmates in school, Mr. Gage, but I claim that as a fact from time to time when I am trying to get some votes among hospital administrators. Maybe it is better for you to keep quiet.

STATEMENT OF WARREN W. SIMONDS, PRESIDENT, LOUISIANA HOSPITAL ASSOCIATION, ACCOMPANIED BY CHARLES R. GAGE, EXECUTIVE DIRECTOR, LHA

Mr. SIMONDS. Mr. Chairman, I am Warren W. Simonds, associate administrator of the Baton Rouge General Hospital, Baton Rouge,

La. I appear today as president of the Louisiana Hospital Association, a nonprofit federation of public and private hospitals, both nonprofit and proprietary. Our membership includes practically all the hospital beds in Louisiana.

With me today, as noted, is Charles R. Gage, executive director of the association, and I might note there are several other members of the association in the audience. We appreciate the opportunity to appear here today.

There are several features of H.R. 1 with which we are in complete agreement and there are several others which we believe not to be in the best interests of the public or of hospitals.

The issue of overriding importance to hospitals in Louisiana and, we believe, to hospitals throughout the Nation, is the authority which would be granted to States by section 232 to determine cost reimbursement for the care of medicaid patients.

In our opinion, this section clearly is intended to permit the States to pay less than would be payable under the medicare formula, which formula we think does not now fully compensate hospitals for their true costs.

Section 232 as presently written provides that payment for inpatient hospital services under the medicaid and maternal and child health programs shall be determined "in accordance with methods and standards which shall be developed by the State, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII."

Since hospitals are reimbursed at cost for services rendered under title XVIII, if we are to be reimbursed in accordance with another standard or formula developed by a State agency which cannot exceed reasonable cost as determined for medicare patients, it appears the new cost determination will either be the same as the medicare cost or less. If it turns out to be the same, we question the need to require hospitals to compute their cost on two different bases. If the cost is computed to be less than for medicare patients, we maintain that hospitals and their paying patients are in no position to absorb any additional unreimbursed costs.

In responding to an assertion that adoption of section 232 may result in development of 50 different definitions of cost, all less than medicare cost, with multiple accounting problems, the Commissioner of the Social and Rehabilitation Service of the Department of Health, Education, and Welfare wrote one of our sister hospital associations last year in part as follows:

Although it is possible that the existence of multiple reimbursement plans may complicate reimbursement at first, once these plans are tested and perfected, states will undoubtedly profit by one another's experiences. Reimbursement plans which have been demonstrably superior will be adopted by more than one state. While some temporary inefficiency or administrative complications might also occur, in the long run this proposal will foster independence and innovation among States.

We reiterate, if States are going to be allowed to experiment with developing reimbursement programs which are limited on the maximum side to cost, the resulting cost to the medicaid program may be

less, but adopting a formula for computing cost will not insure that the cost itself is reduced.

The inescapable result will be that the private patients who are not beneficiaries of either the medicare or the medicaid programs will find their bills inflated in order for hospitals to recover the amounts not reimbursed through an inequitable medicaid formula. Our experience in the past prior to the adoption of title XVIII was that hospitals were faced with accepting whatever the welfare department or the health department had in its budget to care for the patients for whom they assumed a responsibility.

We suggest that instead of section 232, a substitute section be drafted to stipulate that when hospitals provide care for patients admitted under title XVIII or title XIX of the Social Security Act, or any other program for which the Federal Government is responsible for payment either in full or in part, the institutions be reimbursed at cost with the actual cost being determined in accordance with the American Hospital Association's statement on financial requirements of health care institutions and services.

We believe it is imperative and only fair that the Government as a purchaser of hospital services participate in meeting the hospital's full cost of providing services in the community on the same basis as other payers for similar services. This would require the deletion of the limiting language contained in section 1861(v)(c) of Public Law 89-97 and inserting language defining the term "reasonable cost" to mean "the total monetary resources which a health care institution needs or will need to provide the services it offers."

We believe adoption of section 228 which provides for advance approval of extended care and home health coverage under medicare will go far to alleviate certain inequities and hardships presently experienced by extended care and home health care agencies. We commend this section to you.

In the interest of saving time, we refer you to a statement made by this association to the Senate Finance Committee on September 22, 1970, in which we expressed our opposition to Senator Bennett's amendment to establish professional standards review organizations by medical societies. We support and encourage and thoroughly believe in the principle of peer review, but we believe Senator Bennett's amendment as originally presented had serious deficiencies, many of which were outlined in our testimony on September 22, and, I might say parenthetically, Senator, I was not aware there was a revision to this which we will have to get together and take a look at.

Senator BENNETT. You probably were not aware of the original text because it never included a proposal to establish professional standards by medical societies.

Mr. SIMONDS. I can't comment on that, sir.

Senator BENNETT. So that is my only comment at this point, Mr. Chairman.

Mr. SIMONDS. Thank you.

We believe that medical audits and utilization review are properly functions of the organized medical staff which operates within an institution and not of a medical society or other outside organization. In the event the organized medical staff within an institution does not

establish a functioning peer review mechanism, establishment of an outside utilization review team or PSRO would be logical.

We believe section 243 which establishes an appeal for providers of care from determination involving their cost reports is a step in the right direction. Unfortunately, this section does not provide judicial review where the Secretary affirms the Provider Reimbursement Appeals Board's decision. We request that a provision be added to allow judicial review of all administrative decisions adverse to the provider.

As a practicing hospital administrator, I am in contact from time to time with the administrators of other health care facilities in Louisiana and in other States and with the financial managers of these institutions. I am convinced that monetary savings can be made in the area of deductibles by revising the spell-of-illness concept of the medicare law to provide beneficiaries with unlimited inpatient hospital care—365 days a year—with a deductible per admission, plus a small daily charge for each day of hospitalization. It is believed that with no increase in cost to the program the deductible could be considerably less than the current deductible of \$68 with an additional payment of \$1 per day of hospitalization. This would eliminate major administrative problems and could save substantial amounts in reduced administrative costs. We urge the committee to improve the medicare program in this manner or to at least require the Department of Health, Education, and Welfare to conduct experiments along this line to determine the practicality of our premise.

The Louisiana Hospital Association believes that the majority of the citizens of the United States are more concerned about the cost of catastrophic illness than they are about the cost of minor illnesses. Most Americans can afford, either through insurance or through other resources, the occasional hospitalization which happens to each of us, but it is natural to fear unusually high costs of a catastrophic illness which may result in an individual having to sacrifice his life savings and/or sell his home in order to meet monumental hospital and medical bills.

We support the concept of catastrophic health care insurance and believe adoption of this type of program would be well received by the health professionals of our Nation as well as by the citizens.

Mr. Chairman, as the complexity of the operation of health care facilities increases, we believe that the university programs in hospital administration need to be strengthened so that adequate numbers of qualified administrators or managers will be available not only for hospitals but also for community health agencies, planning councils and other functions.

Inasmuch as the Senate Finance Committee has the responsibility for medicare and medicaid, and since these two programs have been the leading forces in intensifying the demands for trained administrators and managers, we believe it would be appropriate to make some provision to strengthen the accredited schools of hospital administration. We have discussed this problem with the executives of the association of university programs in hospital administration who tell us that the present funds for supplements, student assistance, et cetera, are only available to hospital administration programs taught in schools of public health.

We would like to introduce and leave with you a concise statement of the problem and recommended solutions which have been prepared by the association of university programs in hospital administration. We commend it to your earnest consideration. I have the statement here, Mr. Chairman.

(The statement referred to follows:)

IMPROVING HEALTH SERVICES MANAGEMENT

The Problem: Major changes in health services finance and delivery create new management requirements at all levels from hospitals to government agencies. These new needs are superimposed on a system which is already *undermanaged* and therefore unable to respond effectively to demands for better health services and more public accountability. An investment in management development and capacity must be made as part of any system improvement.

Hospital and Health Administration is a relatively new but well established profession. Public support for this field has been peripheral to other programs and very limited. Any new federal health program must recognize limits on effective implementation imposed by the shortage of professionally trained health administrators and include provisions to resolve the problem.

Existing Resources: Thirty universities offer master's degrees in Hospital and Health Administration. These programs have very limited resources with which they train future administrators, conduct continuing education to improve present administrators, prepare new faculty, conduct research on the health system. These programs are accredited by an agency recognized by the U.S. Commissioner of Education and are bound together in a corporate body organized for their improvement.

The thirty graduate programs have the potential to overcome the problem of health management capacity. But they are small, with an average annual enrollment of 26 students each and less than four full-time faculty members.

Present federal support is limited to project and traineeship grants under Section 306 and 309 of the Public Health Service Act. These grants have fared poorly in competition with fields of public health with no management orientation and draw upon an appropriation which has been virtually stable for the last four years and is projected to remain unchanged. *It is clear that an investment in management development must be mandated by those who understand its importance to the success of any health program. The management problems of Medicare and Medicaid prove this point.*

What is Needed: Support to accredited graduate programs in Health and Hospital Administration for: Faculty Training, Faculty Expansion, Student Support, Continuing Education, Community Consultation Services.

A competitive grant program on the order of five million dollars a year is recommended. This amount, though modest, far surpasses all available resources and would substantially upgrade the nation's health management training capacity.

The CHAIRMAN. Let me just ask you about the catastrophic problem.

Where you have people who come into your hospitals without insurance against major medical problems, what do you do with catastrophic situations that run up into a very huge medical bill; how do you handle it? Do you carry them on the books for a long time, try to move them over into charity hospital, or what?

Mr. SIMONDS. Well, those two options, Mr. Chairman, are both available. Some folks come to us and have the capability within resources or the family gets together and they divide up the balance that is due among the various sons and daughters and everybody assumes a portion of the burden.

Sometimes individuals have to go into bankruptcy; sometimes we are able to effect a transfer of a patient before discharge to a charity hospital facility. These are all possibilities.

The CHAIRMAN. If we administered this in the same way and in the same bookkeeping fashion that we administer medicare, wouldn't

you know pretty well how to go about getting reimbursement for your expenses?

Mr. SIMONDS. Yes, sir.

The CHAIRMAN. All right.

Now, there is one other thing that concerns me. In this bill we are going to take care of the disabled under medicare. That is a big additional Federal expenditure. If we add catastrophic to that, we will have another major program. Are we going to be needing more facilities? I didn't see anything in your testimony to suggest how you think we ought to go about getting additional facilities. Can you make a suggestion on that?

Mr. SIMONDS. Yes, sir, Mr. Chairman; I can.

I think that, on the average, hospitals in the United States are utilized to the extent of approximately 65 or 70 percent average daily occupancy. This is a problem in the hospital which I operate, the Baton Rouge General Hospital, in that we will average approximately 75, perhaps a little higher this year, 75 or 80 percent of occupancy. I think there may be some situations in which the public might have to begin to tolerate perhaps lengthy—I say “lengthy”—perhaps a 3-, 4-, 5-week or perhaps even a 2- or 3-month delay for elective procedures. We would obviously have to take care of emergencies, but I think the answer to your question is the hospitals of this Nation will have to operate at a higher percentage of occupancy which can only be accomplished given the cooperation of their medical staffs.

The CHAIRMAN. What is your suggestion, Mr. Gage?

Mr. GAGE. Mr. Long, I would like to think that with proper utilization, review, and control of admissions, control of the length of stay, I would like to think that with the availability of catastrophic illness it wouldn't automatically mean there would be more catastrophic illnesses, that the people who are having catastrophes now are already being taken care of; they just can't pay for their bills. This would not, I think, increase that length of stay or make more of that type of illness. It would just make it a little bit easier for them to see light financially.

The CHAIRMAN. In other words, they are already being cared for? The doctors are already providing the service; the hospitals are already doing the job? The problem is that when they leave the hospital they are hopelessly in debt?

Mr. GAGE. That's right.

The CHAIRMAN. And the hospital has debts on its hands that might never get paid?

Mr. GAGE. This type of illness has to be taken care of. This is not a minor illness or something that can be put off. This is the type of thing that people have to be hospitalized for and they will—and they can not pay for it now.

As I see it, a catastrophic provision would merely pay for it and not create more of that type of illness. Nobody wants to get sick.

The CHAIRMAN. So when some have argued that to take care of catastrophic insurance would tend to distort your use of medical facilities in that area as compared to, let's say, the area of preventive illness, then do I take it that your reaction to it is that you are taking care of this already, that you would not be providing any additional service?

It is just that there would be a way arranged to pay for it which does not now exist.

Mr. GAGE. I would like to think that would be true. It perhaps ought to be considered that we would write into the provision some type of outpatient care for a person who does have an illness but who could be cared for in his home, which would save hospital dollars; and here, again, I am banking strongly on some type of utilization review to get those patients out when they need to go.

The CHAIRMAN. There is one other thing that concerns me. It seems to me we are not making the best use of what we have. I heard complaints about difficulty getting doctors in rural hospitals and also in New Orleans in the general practice area, because everybody seems to want to specialize.

Why couldn't or why shouldn't these medical schools—and if they don't do it why shouldn't we, as a condition of grants we are making to them, insist they require in their admission that some of these students they are admitting should agree to serve in some of these rural hospitals or agree to go into general practice for a while to prevent us from developing a shortage in one area?

Mr. SIMONDS. I think, Mr. Chairman, if I may comment on that, that it might be well, and I think I read someplace there is already a proposed regulation or perhaps something relating to scholarship funds that young men and women going into medical school in return for these scholarship funds would agree to work for a certain length of time in rural or outlying communities and, hopefully, once they get out into these rural areas and get to understand the country life, they might like this and agree to stay on.

The CHAIRMAN. Well, even if they don't, somebody has to do it. If they do it for a while, especially when they are starting out, that would render a service. The experience I have had is that we have a shortage of doctors in certain areas, yet at the same time we have boys standing in line trying to go to medical school. I think we should say, "We can get you in there all right, if you would be willing to serve where you are needed most."

Mr. GAGE. We are really getting out of our own area of competency here when we talk about the practice of medicine because we are not physicians. But I can say from the hospital's point of view, that we are cooperating with the Student American Medical Association now in a program which encourages medical school students to work each summer in rural hospitals in our State, whereby the administrator and the medical staff will take one or two students, bring them to the rural community, pay them a small stipend during the summer vacation period, so the student may work with a practicing physician, work in a hospital, do various chores, to help him get adjusted to the idea of rural life; and the thought by the Student American Medical Association and the AMA and our State medical society and by our hospital association is that in this way we will encourage students in their formative period to get accustomed to practicing in rural areas. We think this is going to help some.

The CHAIRMAN. Senator Bennett?

Senator BENNETT. Mr. Chairman, just one or two questions: Is the length of stay in your hospitals increasing or decreasing?

Mr. SIMONDS. The length of stay in our hospital, sir, has remained stable both before and after medicare, interestingly enough. Louisiana had a strong Kerr-Mills program before we came into medicare.

Senator BENNETT. I am not talking just about medicare patients but all patients.

Mr. SIMONDS. Yes, sir; I was coming to that. In general, the stay is remaining the same; it is about five and a half days average for all patients. It is about 10 days for 65 and over.

Senator BENNETT. It is fairly low on the scale compared with other States?

Mr. SIMONDS. Yes, sir.

Senator BENNETT. Probably couldn't be reduced much. This is an interesting day for me because I began it with a conference with representatives of the Utah Hospital Association who made the statement that since the Bennett amendment was introduced 2 years ago, probably in anticipation of its adoption, the length of stay in general in the country is decreasing, but apparently yours is level.

In your statement you make a strong pitch, which I can understand, for the validity of your in-house review process. Our friends from Utah this morning, who are hospital administrators, smiled and said in many hospitals the in-house review is a paper tiger. Is that true in your hospital?

Mr. SIMONDS. No, sir. We have a strong utilization review committee at this present time in our hospital. It is being effective; it is becoming more effective every day, I would say.

Senator BENNETT. Do you realize that under the Bennett amendment if you do have a strong in-house utilization review process that it can take over the review in that particular hospital provided there is an occasional overview from the PSRO organization outside to see that it maintains its standards?

It is not the intention of the Bennett amendment to supplant your in-house review—

Mr. SIMONDS. I see—

Senator BENNETT (continuing). With outsiders but to validate its effectiveness and to get rid of the paper tiger.

Mr. SIMONDS. Very good.

Senator BENNETT. You say in the event the organized medical staff within an institution does not establish a functioning peer review mechanism, establishment of an outside utilization review team would be logical.

Would you change the words "establish" and "functioning" to indicate that if there does not exist an effective review mechanism that an outside review team would be logical?

Mr. SIMONDS. Yes, sir; I would go along with the word "effective" very definitely.

Senator BENNETT. Then, of course, and I recognize that you are concerned chiefly about the processes of medical service in hospitals. There is a great deal of medical service given in nursing homes where they can't have in-house review process?

Mr. SIMONDS. That is correct.

Senator BENNETT. Would you think that professional review mechanisms might be useful in reaching the patients who are being served in nursing homes?

Mr. SIMONDS. Yes, sir; I would think this might be a valuable approach inasmuch as at least in our particular section all physicians practicing in almost all of the nursing homes and probably nursing homes do not have the organized medical approach to the extent the individual hospital does. In other words, some organization of this type might be pertinent.

Senator BENNETT. Are you aware of the experiment that has taken place in New Mexico?

Mr. SIMONDS. No, sir; I have not heard of it.

Senator BENNETT. I think that might be a very interesting thing to you and very much worthwhile; and I am sure the staff of the committee can provide you with the details. All of the doctors in New Mexico, 800 of them, organized a peer review mechanism. They reviewed all the hospitals; they reviewed all the nursing homes; they discovered that 30 percent of the patients in nursing home did not need to be there and I was told this morning that they have agreed that 50 percent of the services in hospitals in New Mexico are adequate; in other words, there is no necessity for them to review those particular services; and you heard Dr. Dowda say that PSRO had reduced the cost of Medicaid in Georgia very substantially, so I hope you will go home and take another look at the value of professional review. It is based on the theory that only doctors should review the work of other doctors, that we shouldn't have a clerk hired by an insurance company who undertakes to say whether a patient has been in a hospital too long or whether a particular surgical procedure was unnecessary; and I hope—I am encouraged by the fact that your statement says—you are still standing on the statement of 2 years ago. A lot of things have happened to the amendment in the last 2 years.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. I might say to you I am very much interested and concerned about the problems of these families who have a catastrophic illness, but I have on question:

What provisions can you suggest if we put in such a program that will prevent the catastrophic program from becoming a national health program for everybody?

Mr. SIMONDS. Mr. Curtis, I think the best thing I can say about the catastrophic health insurance program or perhaps the best analogy is to compare it to residential fire insurance. Most of us don't deliberately go around setting fire to our own homes. I guess there are a few folks who do so for a variety of reasons; by the same token, most of us don't try to go around having strokes that keep us in the hospital 3 months and so on.

Senator CURTIS. No; I understand that. I was thinking of the political end, the definition of catastrophic. I want to do something about catastrophic illness; I am not arguing about that at all. I think these people who are faced with medical bills of \$20,000, \$30,000 and so on, and even possibly lesser amounts, that that should be of concern. In our definition of catastrophic do you have any suggestions we could write in that would prevent next year the definition of catastrophic being lowered a little bit, and next year, and so on, and in about 5 years by definition it covers most of people's illnesses?

Mr. SIMONDS. Mr. Curtis, I think you have touched upon a point which has concerned me greatly since the advent of medicare, of the redefinition of a variety of things—reasonable costs, for example, and I have really no way, since politics is really out of my realm of expertise; I could not offer any suggestions.

Senator CURTIS. It is out of mine, too, but it worries me at times.

Mr. SIMONDS. It worries us, too, sir, in that we have seen a variety of areas in which we started out in 1966 with a certain definition and certain understanding, and by the time we reach 1972 it has been considerably revised and I share your concern.

Senator CURTIS. Oh, yes. Medicaid was presented to this committee as something that would cost a couple of hundred million, maybe \$400 million.

Well, I just thought maybe you had a suggestion on that and I hope this committee can arrive at—or somebody will come along with a definition that is acceptable.

Mr. GAGE. I would think if I had to spend the first \$10,000 of my money in order to collect on some catastrophic illness coverage beyond \$10,000 that would be a pretty good deterrent.

Senator CURTIS. I am not worrying about the patient doing those things.

Mr. GAGE. I am thinking about the medicare age limit. We have been concerned about the fact that medicare started at age 65. What happens when somebody says make it 62 or make it 60, 45—that is another approach to national health insurance. My personal feeling is that by providing a catastrophic illness coverage it would be like a safety valve, taking off some of the pressure which presently exists for a national health insurance.

Senator CURTIS. I think that is true.

Mr. GAGE. I may be naive in saying that but I feel that way and hopefully that the general public will accept it in the same way.

Senator CURTIS. Well, I think that is true. I can't quarrel with you at all and I am just inquiring that we might write the very best one possible because I think it might fall in the same pitfall as family assistance now. It has gotten to be an auction.

The proponents originally started out with \$1,600 and raised their own bid to \$2,400 and somebody else has bid \$3,000 and somebody has bid \$4,000, \$4,200, and we aren't near the election yet. The auctioneer's hammer isn't about to go down and I don't know what is going to happen. What I am trying to say is we have a problem in the catastrophic illness that deserves to be met and we ought to do our very best to write whatever is done in such a way that it does that job and no more.

I was impressed by your remarks concerning the reimbursement of hospitals by medicare. Would you regard the provision in the House bill as being worse than what it is now?

Mr. SIMONDS. Mr. Curtis, I think that when the reimbursement of hospitals is changed in such a way as to say the Government money—and I think this is the basic goal of some of the provisions—that the institutions that are providing care can only recover their losses by passing it through in the form of price changes to paying patients or those who pay for them.

Senator CURTIS. That is wrong and I don't like it; but what I mean is there anything in this bill that the House sent over to us that makes the situation worse than it is now?

Mr. SIMONDS. Section 232.

Senator CURTIS. You think that is not an improvement to our present situation?

Mr. SIMONDS. No, sir; I don't see how it would improve the situation. It would complicate it tremendously.

Senator CURTIS. In your remarks concerning the hospitals, would that apply equally to the extended care facilities?

Mr. SIMONDS. Yes, sir; I believe it could.

Senator CURTIS. This week I received a letter from a very fine individual who manages an institution in Nebraska. They are closing out their extended care facilities because of the arbitrary procedure for reimbursement on an item, I think, of \$50,000. They have to accept \$37,000 and they cannot stand the \$13,000 loss so they are just closing it.

We hear an awful lot about medical services in the rural areas and I am concerned about it, too; but my first objective is to get the Government to stop closing medical facilities and that is what is happening in my State. They just hound little communities, nitpick about one thing or another in their hospital. I imagine more patients, or as high a percentage of patients, walk out on their own strength as any other hospital. But they have lost sight of the fact that the medicare was an act to help people meet the financial burdens of illness and not to take over the licensing and running and supervision of every hospital and every doctor in the country by the Federal Government. But I don't think that message has ever gotten to Baltimore.

Mr. GAGE. Mr. Curtis, may I make a statement on that?

Senator CURTIS. Certainly.

Mr. GAGE. I think there are several features in H.R. 1 that will help that situation with the extended care groups. I think there is one that would require a preliminary certification of the availability of benefits. At present, I understand that it is possible for an extended care patient to be taken care of in a home and be discharged and then the extended care facility would find out that person had already exhausted his or her benefits and was not going to be paid. Occasionally an extended care facility, I understand, is given assurance that the coverage is available and they take care of the patient and then they find out that something else had happened—the record wasn't complete and, therefore, you wouldn't get paid.

Another thing that I think is a real problem with hospitals as well as nursing homes and extended care facilities is the fact that occasionally regulations are handed down that I think are beyond the intent of Congress, that change a procedure.

We are facing now a proposed regulation by the Secretary which will require hospitals over 100 beds to use a departmentalized system of accounting even if they haven't done it before. This is a regulation. Now, we have gone along all these years with this accounting system trying to tighten it up and make it more effective and be able to comply with the requirements; and now here comes a proposed regulation

down the pike that will make a lot of hospitals change their accounting system.

Senator CURTIS. How much do you suppose that is costing the Government for all these auditing activities and how much is it costing the hospitals to defend themselves from it? And it is taking a lot of money that could be used heal people?

Mr. GAGE. It will cost the hospitals a considerable amount of money to have to change their accounting system to have to comply with this proposed requirement.

HEW takes the position that if this happens it will save the Government a lot of money, and it may save the Government considerable money—I have no way to know—but if it does save the program any money it doesn't mean that the cost will be reduced. It will just mean the Government will be paying less for that service and the hospital will have to pick up whatever it does not collect now and pass it on to the paying patient. Changing a method of reimbursement does not necessarily change the cost.

Senator CURTIS. That is all, Mr. Chairman.

Senator JORDAN. Some people when they speak of catastrophic illness think only of physical illness, the need for an artificial kidney or something like that. In your concept of catastrophic illness, would you include mental illness?

Mr. SIMONDS. Mr. Jordan, I think that is a problem which has been approached in many States on quite a broad State-financed basis. Usually in an acute care institution such as my own, this does not present a particular problem if there is a patient who has a psychosis or some neurotic problem. A short-term treatment roughly comparable to the surgical patient or medical patient usually is the extent of the care the patient receives in our institution.

However, a person who goes into prolonged care might well fall into this category.

Your point, I think, is well taken that this might be an area we ought to look into; it hadn't occurred to me prior to this time that the mental patient might very likely be a person who would also fall in this category.

Senator JORDAN. Thank you.

The CHAIRMAN. Senator Nelson?

Thank you, very much.

I just want to add one thing to the record at this point—a letter that I have been sending out to a great number of people who have been writing me about section 232, indicating that we will definitely consider the points that you have raised.

Frankly, I think if the other hospital associations have done half as good a job as you have of alerting their Senators to the problem in section 232, you will get the relief you need from it.

(Letter referred to by the chairman follows:)

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

DEAR FRIEND: This is in reply to your recent letter recommending deletion of Section 232 of H.R. 1, the Social Security Amendments of 1971. That provision, as you know, would free States of the requirement that they reimburse hospitals for care provided under Medicaid on the same basis as hospitals are reimbursed under Medicare.

Section 232 originated from a concern expressed some time ago by governors that the Medicare formula was inappropriate for the States and resulted in excessive reimbursement to hospitals. The States pointed out that this tandem relationship with Medicare reimbursement inhibited the development of payment approaches designed to promote greater efficiency and economy in hospital operations.

To my mind, the change embodied in Section 232 was perhaps more appropriate when first proposed than it is today. For example, the 2 percent allowance or "bouns" previously paid on top of actual costs under Medicare, which the States feared, has now been discontinued. That particular item was a special, costly bone of contention which no longer obtains.

Similarly, other provisions in H.R. 1, relating to prohibition of Medicare payment to hospitals of costs which are unreasonable in relation to costs for comparable services in similar hospitals should also help relieve some of the concern over the Medicare formula which had been expressed by the States.

In view of the changes that have already been effected in the Medicare reimbursement formula, and the additional changes which would be made by other provisions of H.R. 1, Section 232 would appear to have lost much of its significance. That being the case, and because of my confidence that no Member of the Committee wants to deny hospitals full reimbursement of the reasonable costs of providing necessary care to Medicaid patients, it seems to me that the Finance Committee would seriously consider deleting Section 232.

Again let me assure you that we are carefully reviewing the present necessity for Section 232 in light of these changed circumstances.

Sincerely,

RUSSELL B. LONG, *Chairman.*

The CHAIRMAN. Is Mr. John Pickens here? If he is not here, we will print his statement.

(The prepared statement and attachments of Mr. Pickens follow. Hearing continues on p. 2548.)

STATEMENT OF JOHN K. PICKENS, ON BEHALF OF THE AMERICAN NURSING HOME ASSOCIATION ON THE MEDICARE AND MEDICAID PROGRAMS

SUMMARY

I. ANHA supports Senator Long's Bill on catastrophic illness and recommends inclusion of skilled nursing homes and intermediate care facilities.

II. Amendment No. 823 to H.R. 1.

(a) Senator Bennett's proposal to establish Professional Standards Review Organizations (PSRO).

(b) PSROs should (1) insure that patients are placed in the least expensive type of facility that can satisfy the patient's needs, (2) identify facilities that are meeting appropriate standards, (3) identify cases of excessive or inadequate health services and take appropriate corrective action, and (4) work with all of the health professions and institutional providers to insure that health services are delivered efficiently and economically.

(c) The American Nursing Home Association continues to support Senator Bennett's amendment.

III. Discussion of H.R. 1 as passed by the House of Representatives.

Section 207—Incentives for Comprehensive Care Under Medicaid.—Disincentives would be provided to discourage prolonged stays in institutions. Specifically, there would be—

(1) An increase of 25 percent (up to maximum of 95 percent) in the Federal Medicaid matching percentage to States under contract with HMO's.

(2) A decrease in the Federal medical assistance percentage by one-third after the first 60 days of care in a general or TB hospital.

(3) A reduction in the Federal percentage by one-third after the first 60 days of care in a skilled nursing home unless the State establishes that it has an effective utilization review program.

(4) A decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after 275 additional days of such care during an individual's lifetime.

(5) Authority for the Secretary to compute a reasonable cost differential for reimbursement between skilled nursing homes and intermediate care facilities.

Regardless of the savings that may accrue, states would be forced to use lower cost facilities, that are unable to meet the patient's needs, or completely deny any assistance. Estimates of the financial impact on 22 states are included in the testimony.

There are several existing or proposed controls on utilization which begin with physician orders and a variety of systems already established by state agencies. Amendments to Title XIX, passed by Congress in 1967 effective in 1969, include several controls; but the Secretary did not publish proposed regulations until May of 1970 and final regulations published only recently. H.R. 1, Sections 233, 237 and 238, provides for utilization review, advance approval of admissions which could be made applicable to Title XIX, and state health agency plans for professional review of utilization. In addition, Senator Bennett's amendment would greatly improve controls. Utilization should be based on medical necessity and not by withholding federal funds, regardless of patient's needs. Section 207 should be deleted.

a. Section 221: Limitation on Federal Participation for Capital Expenditures

Federal programs support a high percentage of all long term care patients; therefore, this limitation amounts to "franchising." The Association is concerned over lack of representation of all providers on the agencies and over the ability of local and state planning agencies having the capability of making impartial decisions. ANHA recommends that the Secretary's decisions be subject to judicial review and that state and local agencies include representation of all providers on an equitable basis.

b. Section 222: Prospective Reimbursement Experiments

The Secretary has asked for authority to implement desirable methods of reimbursement as soon as they can be developed. ANHA supports his request. The bill does not provide that the experiments and demonstration projects should include financial incentives for providers as recommended by the staff of the Senate Finance Committee. An amendment is presented to include this clarification.

c. Section 223: Limitations on Coverage of Costs

(1) The Secretary is given authority to set "ceilings" on individual items of cost, such as food or utilities, as well as total cost. The authority should be limited to total cost.

(2) The bill authorizes providers to make excess charges after the Secretary has notified the public but does not establish procedures which would require the Secretary to provide the notice when appropriate. Procedures should be added to this section.

(3) The decisions of the Secretary should be based on hearings and subject to judicial review.

d. Section 225: Limits on Skilled Nursing Home and Intermediate Care Facility Costs

The average per diem costs for skilled nursing homes and intermediate care facilities countable for Federal financial participation under Medicaid would be limited to 105 percent of such costs for the same quarter of the preceding year.

With respect to both skilled nursing homes and intermediate care facilities, the Secretary is authorized to increase the specified percentage limitation to take account of increases in per diem costs which result directly from increases in the Federal minimum wage or from other changes in Federal law.

ANHA recommends elimination of this as discrimination and unnecessary in view of present controls. Most state rates have not been increased to include 4 step increases in minimum wages and other costs. Phase II controls are more effective.

e. Section 226: Payments to Health Maintenance Organizations

Medicare beneficiaries could choose to have all covered care, except emergency services, provided by a *health maintenance organization* (HMO).

ANHA believes definitions and standards for HMO's should be spelled out in far more detail. ANHA opposes using funds generated from care of non-Medicare patients to expand benefits of Medicare patients as unfair and invalid.

f. Section 228: Advanced Approval of Extended Care and Home Health Coverage Under Medicare

Advanced approval would improve utilization and help solve the problem of retroactive denials. The bill should be amended to include Medicaid admissions from hospitals.

g. Section 229: Authority of Secretary to Terminate Payments

The Secretary should have authority to control abuses by terminating payments to abusers of the programs.

h. Section 233: Amount of Payments Where Customary Charges Are Less Than Reasonable Costs

ANHA supports this provision.

i. Section 234: Institutional Planning Under Medicare

Health institutions under the Medicare program would be required to have a written plan reflecting an operating budget and a capital expenditure budget.

ANHA supports this with certain reservations and modifications.

j. Section 237: Utilization Review Requirements Under Medicaid

Hospitals and skilled nursing homes participating in the Medicaid and maternal and child health programs would be required to have the same type of utilization review committee with the same functions as are required in the Medicare program.

ANHA supports this providing it is superseded by the Bennett Amendment when PSRO's become fully effective.

k. Section 238: Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under Medicare

If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where institutionalization is no longer necessary, payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

ANHA supports this provision.

l. Section 241: Program for Determining Qualifications for Certain Health Care Personnel

The Secretary of Health, Education, and Welfare would be required to develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting specific formal criteria now included in Medicare regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of the Medicare and Medicaid program.

Affected career-area personnel would include practical nurses, therapists, laboratory technicians and technologists, X-ray, technicians, psychiatric technicians, or other health care technicians.

ANHA supports this provision.

m. Section 242: Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

Present penalty provisions relating to the making of a false statement or representation of a material fact in any application for Medicare payments would be broadened to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral, by providers of health care services. The penalty for such acts, as well as the acts currently subject to penalty under Medicare, would be imprisonment up to one year, a fine of \$10,000, or both. Similar penalty provisions would apply under Medicaid.

Anyone who knowingly and willfully makes, or induces the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or home health agency in order to secure Medicare or Medicaid certification of the facility or agency, would be guilty of a misdemeanor punishable by up to 6 months' imprisonment, a fine of not more than \$2,000, or both.

ANHA supports this provision.

n. Section 243: Provider Reimbursement Review Board

The Senate Amendment to H.R. 17550 (Section 281) is far preferable to Section 243 as it allows class actions, among other things, if the amount equals \$10,000 and was worked out by representatives of SSA, the Committee Staff and ANHA.

o. Section 251: Physical Therapy Services

This section, among other provisions, limits payments to institutions for therapy costs to the amount that would normally be paid as salary if the therapist was an employee. Many therapists in private practice would not accept the lower level of payment and extended care facilities could not absorb the differences. Adoption of this provision could eliminate participation of large numbers of ECFs in the program.

p. Section 254: Intermediate Care Facilities

House Amendment adopted in December, 1971, as Public Law 92-223.

ANHA believes present law should be amended to provide for two levels of care, (1) a level with nursing service and (2) a level without nursing service. State institutions should meet the same requirements as other providers. Supplementation should be permitted.

q. Section 262: Medicare Fair Hearings

Fair hearings, held by Medicare carriers in response to disagreements over amounts paid under supplementary medical insurance, would be conducted only where the amount in controversy is \$100 or more.

ANHA supports the Ribicoff Amendment reducing the amount in controversy to \$25. Hearing procedure should be spelled out in some detail as SSA has always opposed a full administrative hearing.

r. Section 269: Requirements for Nursing Home Administrators

States would be permitted to provide under Medicaid for a permanent waiver of a nursing home administrator who had been an administrator for more than 3 years prior to July 1970.

ANHA opposes this. ANHA supported the Kennedy Amendment in 1967 providing for the licensure of Nursing Home Administrators. Almost all states have had programs for licensure for the last 3 years which have contributed towards upgrading nursing home administrators. Program should not now be weakened or downgraded.

IV. Administrative and Judicial Review

ANHA supports *full* administrative and judicial review.

STATEMENT

Mr. Chairman, and members of the Committee, I am John K. Pickens, Legislative Counsel of the American Nursing Home Association.

The American Nursing Home Association is a federation of state associations which represents some 7,000 long term care facilities, with a bed capacity of over 400,000. Our Association membership includes both proprietary and non-proprietary facilities located throughout the country. A substantial number of the membership participates as providers of long term care under the Medicare and Medicaid programs.

The Association appreciates this opportunity to appear before the Senate Finance Committee. The testimony I will present is divided into four sections. The first section will be the Association's views on (1) Senator Long's Catastrophic Illness Bill and (2) a major amendment to H.R. 1, proposed by Senator Bennett. I will then discuss those provisions of the bill as passed by the House of Representatives that are of primary concern to the members of our Association. The fourth section will be comments on desired changes that are not included in H.R. 1.

I. CATASTROPHIC ILLNESS BILL FIRST PRIORITY

A. Senator Long's Bill

Senator Long's catastrophic illness bill should receive immediate consideration. The principal conditions which maim the elderly and bring on catastrophic situations are heart disease, stroke, and cancer. There are many others. However, we see no need for requiring 61 days of hospitalization prior to possible transfer to an ECF. This, in our opinion, should depend on the condition of the patient. Frequently, these catastrophic cases stabilize in the first 15 to 20 days and a less intensive type facility than a hospital, such as an ECF or Skilled Nursing Home, will suffice at far less cost. Then, at some point in many cases, a transfer to an even lesser type care facility than an ECF or Skilled Nursing Home, such as an Intermediate Care Facility, may become feasible.

B. Present Co-Insurance and Deductible Provisions Should be Changed

The present hospital and Post Hospital Extended Care services benefit structure under Medicare has contributed to the problem of inappropriate use of institutional services. At the present time, after the patient pays the deductible, he is entitled to 60 days of hospital benefits covering all applicable charges without paying any further deductibles or coinsurance. After 60 days the patient pays the daily coinsurance until he has exhausted the hospital benefit of 90 days in a spell-of-illness. In addition, the patient is entitled to a lifetime benefit of another 60 days of hospital care. On the other hand, after only 20 days in an extended care facility the patient must pay a daily coinsurance until he has exhausted the extended care benefit of 100 days in a spell-of-illness. This situation encourages the patient, the physician and even the state (where the patient is on welfare and eligible for Medicare) to keep the patient in a hospital as long as possible. The often mentioned, retroactive denials of extended care benefits further encourages longer stays in hospitals.

This situation could be rectified in part by relating the number of "free" days in both hospitals and extended care facilities to average length of stay, but in no case allowing for more free hospital than free ECF days. The number of allowable hospital and ECF days should be limited to 50 rather than the present 90 and 100 days respectively. Additional days should be allowed for a certified catastrophic illness under Senator Long's Bill.

C. Savings Through Use of Skilled Nursing Home Facilities

At the time of this Committee's hearings on National Health Insurance on April 26, 1971, Senator Long asked the Department of Health, Education and Welfare for estimates of costs if skilled nursing home benefits were added to his catastrophic illness bill. We do not know whether the Department has ever supplied these figures. We do know that for every extra dollar spent on skilled nursing home care \$2.00 to \$5.00 will be saved in reduced hospital care.

II. AMENDMENT NO. 823 TO H.R. 1 (PEER REVIEW)

Amendment No. 823, proposed by Senator Bennett (originally referred to the Committee on Finance on August 20, 1970) would materially alter present systems of utilization review, which are intended to control unnecessary and excessive usage of institutional care. The Professional Standards Review Organizations (PSRO), established under the amendment, also would supplement or replace other efforts to insure that only services necessary to proper health care are provided: that those services are consistent with professional standards; and that, where appropriate, less costly alternative modes and sites of health care are used. Mr. Bennett has explained his amendment to the Senate on several occasions, and this Committee is very familiar with his amendment.

We have consistently stated that improved, realistic, and innovative utilization of the various forms of less costly institutions encompassed in the generic term "nursing homes" offers the greatest single potential for reducing the cost of health care. For example, there is no reason why nursing homes should be characterized as facilities for the elderly, other than the fact that current usage is largely limited to the elderly. The Association would like to see PSRO's develop the capability of evaluating the health services available in all care facilities in the area and be able to match patient needs with the least expensive type of facility that can satisfy those needs.

The PSRO's should have the ability to evaluate facilities in terms of standards that are necessary to meet patient needs and inform the community on which facilities are maintaining those standards.

ANHA would like the PSRO's to evaluate the patients' needs in terms of health services ordered by the physician and provided by ancillary medical personnel, such as therapists, or by the facility. Where cases of excessive or inadequate health care services are identified, it is our hope that the PSRO's will have the necessary respect of the health care community and the authority to insure that appropriate corrective action is taken.

ANHA expects that PSRO's will work with all of the medical professions and institutional providers to insure that patients receive the appropriate medical services through the most efficient, economical methods.

The health care delivery systems and the controls existing today are not getting the job done. The American Nursing Home Association was one of the first associations in the health care field to support Senator Bennett's amendment, because we agree that responsible physicians, working closely with other health professionals and institution administrators in the community through Professional Standards Review Organizations, offer a real possibility for improvement.

Section 207: Establishment of Incentives for States To Emphasize Outpatient Care Under Medicaid Program

The proposal contains five (5) principle provisions :

(1) The Federal matching percentage for outpatient hospital services, clinic services, and home health services would be increased by 25% (up to a maximum of 95%).

(2) The Federal percentage after the first 60 days of care in a general or TB hospital would be reduced by one-third.

(3) The Federal percentage after the first 60 days of care in a year in a skilled nursing home would be reduced by one-third,

(4) The Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third, and no Federal matching would be available after 275 days of such care during an individual's lifetime except that the 90 day period may be extended for an additional 60 days if a physician certifies that the patient will benefit therapeutically from such an additional period of hospitalization, and

(5) The Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

The stated purpose of the provisions is to encourage states to use lower cost methods of providing health services to patients receiving benefits under Title XIX when more expensive institutional health services are not medically necessary. The effect will be the reduction of the Federal percentage after the stated period, with no consideration of medical necessity. Regardless of any savings that may accrue from the reduction of the use of higher cost services, the added financial burden on states will force the use of lower cost services or the complete denial of benefits when "skilled nursing home services" are medically necessary.

At page 165 of the Special Analysis of the 1973 Budget prepared by the Bureau of Management and Budget, in explaining the decrease in Medicaid outlays in connection with Section 207 of H.R. 1, it states as follows:

"In an effort to promote the use of less costly ambulatory and preventive care, legislation has been proposed to limit Federal matching for care provided in nursing homes and mental hospitals to that needed for active treatment, and to institute cost-sharing provisions for care provided in general hospitals."

I submit that if this is the real purpose of Section 207, the Bennett amendment along with medical audit and review is the most effective answer rather than a meat axe approach which will create real hardships.

The financial impact on states as a result of the proposal is difficult to obtain, but estimates from a few states were obtained last year when the proposal was a cutback to 90 nursing home days, not 60 days as now proposed. Consequently these estimates are far too low and out of date.

1971

Alabama -----	\$4, 000, 000
California -----	20, 000, 000
Colorado -----	4, 000, 000
Connecticut -----	2, 000, 000
Georgia -----	7, 400, 000
Idaho -----	818, 629
Indiana -----	1, 041, 000
Louisiana -----	4, 250, 000
Maryland -----	5, 421, 700
Massachusetts -----	5, 000, 000
Nebraska -----	3, 500, 000
New York -----	105, 000, 000
North Carolina -----	2, 500, 000
Oklahoma -----	18, 000, 000
Pennsylvania -----	13, 100, 000
South Carolina -----	2, 734, 959
Tennessee -----	8, 000, 000
Texas -----	9, 167, 230
Utah -----	2, 000, 000
Washington -----	1, 288, 000
Vermont -----	1, 083, 032
Virginia -----	2, 420, 000

We would like to call the Committee's attention to the existing and proposed methods of determining medical necessity, which are intended to insure appropriate utilization of skilled nursing homes.

The first step is the patient's physician's order for admission. At that point, states have established a variety of review mechanisms, such as requirements for written approval by local representatives of the agency administering the program, classification of patients into various levels of care categories, utilization review programs, etc.

The 1967 amendments included a provision effective July 1, 1969, requiring states to establish "a regular program of medical review (including medical evaluation of each patient's need for skilled nursing home care) or (in the case of individuals who are eligible therefore under the state plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing home. . . ." These 1967 amendments also require periodic inspections by medical review teams in skilled nursing homes and mental institutions of the care being provided, the adequacy of the services available to meet the current health needs of each patient, the necessity and desirability of the continued placement of the patients, and the feasibility of meeting their health needs through alternative institutional or noninstitutional services. Tentative regulations to implement these requirements were not published by the Secretary until May 16, 1970, and final regulations were only recently adopted. Enforcement of these existing legislative requirements should accomplish a major part of the stated intent of the proposed section 207.

H.R. 1 and proposed amendments already before the Committee include other provisions intended to control utilization.

Section 237, if adopted, would require the same or similar utilization review procedures under Medicaid that are presently required under Medicare. Section 228 provides procedures for advance approval of Extended Care and Home Health Coverage under Medicare. This procedure could be extended to skilled nursing home admissions of patients being discharged from hospitals. Section 239 requires State Health Agencies to establish a plan for review by professional health personnel of the appropriateness and quality of care and services under the Medicaid and Maternal and Child Health programs.

Amendment No. 823 to H.R. 1 proposed by Senator Bennett to establish Professional Standards Review Organizations would greatly improve present methods of determining the medical necessity of institutional care.

The existing procedures if carried out, the existing legislation if enforced, the various proposals in H.R. 1, and Senator Bennett's PSRO amendment should control utilization of the more expensive institutional care services through the exercise of professional judgment on medical necessity. Section 207 would withhold Federal funds without consideration of patients' needs.

As Senator Bennett pointed out in a speech on the floor of the Senate on January 25, 1972, the PSRO has become a working reality in states such as New Mexico, Colorado and Georgia. In one state, after a personal evaluation of each patient, it was found that a sizeable percentage of Medicaid patients were not in need of institutionalized care and in another state Medicaid average length of stays in hospitals have been reduced by more than one full day.

The approach of the Bennett amendment is not only fairer, and will ensure that the proper patient receives the proper care, but in the long run will save more money.

Is it fair or even humane, to arbitrarily provide that a bedfast patient has to be moved out of a hospital or skilled nursing home on the 61st day, otherwise the Federal matching funds will be cut, and a patient who does not need the care and should not be receiving institutional care is allowed to remain for even 60 days?

The American Nursing Home Association recommends that Section 207 be deleted.

DISCUSSION OF PROVISIONS OF H.R. 1 AS PASSED BY THE HOUSE OF REPRESENTATIVES

Section 221—Limitation on Federal Participation for Capital Expenditures

The proposal limits Federal payments to institutions when capital expenditures are disapproved by planning agencies. This provision, when applied to the field of long term institutional care, has a much greater potential effect than when applied to other types of facilities. The Federal programs (Titles XVIII and

XIX) contribute to the support of approximately 75% of all patients in non-hospital based Extended Care Facilities and Skilled Nursing Homes. Controls on capital investments by the proposed disallowance of capital related expenditures in computing the reimbursement is an indirect form of "franchise," since relatively few facilities can operate without participating in the federally supported programs.

The members of ANHA are deeply concerned that the planning agencies, which, in effect, will function as franchise boards, will have almost unlimited power to control the long term care field by their recommendations to the Secretary.

The planning agencies frequently must decide between two or more capital expenditure proposals to satisfy a particular need in an area. There are an almost unlimited number of factors that can be considered in making such a decision. It is not improbable that decisions can be influenced by personal or quasi-political factors. The relatively recent development of Comprehensive Health Planning organizations under P.L. 89-749 raises the serious question of whether or not these agencies have developed adequate techniques to properly discharge the functions and properly exercise the authority which the proposed section 221 will assign to them.

During hearings in October, 1969, the Department of Health, Education, and Welfare provided the House Ways and Means Committee the following information:

The Comprehensive Health Planning Program is still in a developmental and organizational stage. State agencies have been established in all 50 states, the District of Columbia, and 5 territories. On the areawide level, 106 planning agencies, servicing slightly more than half the population of our nation, are receiving federal grants; 10 of such agencies are currently operational. It is estimated that 113 planning agencies will be receiving grants by the end of fiscal year 1970 and that 35 of such agencies will be operational.

In the event Section 221 is adopted, we recommend that the decisions of the Secretary be subject to judicial review. The American Nursing Home Association also recommends that the planning agencies, both state and local, include representation of all providers on an equitable basis.

Section 222—Prospective Reimbursement Experiments and Demonstration Projects To Develop Incentives for Economy in the Provision of Health Services

The section increases the Secretary's authority to conduct experiments and demonstration projects, but it does not authorize elimination of the "reasonable cost" concept. The fact that the proposal broadens the existing authority of the Secretary to experiment with payment programs and directs the Department to conduct demonstration projects is a step in the right direction. However, the wide acceptance of the fact that the present "reasonable cost" reimbursement concept has already demonstrated its shortcomings indicates the need for more rapid changes than the House-passed bill permits.

We firmly believe that the incentive reimbursement authority granted the Secretary to participate in pilot projects has failed to attract but a few proposals and has resulted in little progress, because such authority has been construed to allow no reward to the provider of service for reducing costs. Hence, this section provides no incentive to a provider to attempt to develop a project to cut costs. It is a one-sided proposal—only to save the government money. It does not allow the principles of competitive free enterprise to operate. The report of the Staff of the Senate Finance Committee of February 9, 1970 (91st Congress, 1st Session, Committee Print) recognized this at page 89 and recommended that the costs saved the federal government be shared with the provider. We have suggested in our amendments in Appendix A that the Secretary be authorized to enter into experiments with such *true incentive factors*.

Section 223—Limitations on Coverage of Costs Under the Medicare Program

This section authorizes the Secretary to set "ceilings" on the various elements of cost, such as food, supplies, salaries, etc. Providers are authorized to charge patients for costs in excess of the "ceilings" under specified conditions. The authority granted the Secretary by this section to exclude "any part of incurred costs found to be unnecessary in the efficient delivery of needed health services" appears to expand and clarify the authority that has been used by the Secretary since the beginning of the Extended Care Facility program. The Secretary through the intermediaries, has set ceilings on rates of payment based on costs

incurred by other facilities in the area. The expansion of this authority to establish limits on specific items or services, will be interpreted as a legislative "mandate" rather than "authorization." The cost of making the necessary determinations on the many cost factors involved will add to the already prohibitive cost of administering the program. The often mentioned "audit overkill" will be perpetuated and expanded.

The American Nursing Home Association accepts the concept that the program should not pay for all costs simply because they have been incurred, but establishing maximums on total costs will provide an adequate control.

The proposed amendments do not mention whether the Secretary has authority to establish the limits retroactively. Our experience indicates that if the authority is not limited, the Secretary will advise facilities that expenses incurred several years in the past will be disallowed and retroactive adjustments required. The reports of the Committee on Ways and Means on H.R. 1 clearly states that the authority would be exercised on a prospective basis. The proposed section should be amended to require the Secretary to advise the facility of any limits on costs prior to the time the provider delivers the service to eliminate any possibility of misinterpreting the Congressional intent.

The proposal makes no provision for hearings or judicial review of ceilings established by the Secretary. The section should be amended to require that the Secretary's determination will be made only after an administrative hearing, and any provider dissatisfied with such determination shall have the right of judicial review.

The provisions which establish the basis on which the provider can charge the beneficiary for excess costs are in accordance with the original intent that the right of the beneficiary to free choice of institution is guaranteed. However, the present wording permits the provider to make the excess charge only when the Secretary has provided notice but does not specifically require the Secretary to provide such notice. Although the intent may be clear, the section should be amended to establish a procedure whereby the provider can apply for authority to make the excess charge and time limits during which the Secretary must act on the application and provide the public notice.

The section requires that the amount of payment due a provider be reduced to the extent that such payment plus the excess charges exceed the cost actually incurred.

A provider can impose excess charges only to the extent that the actual costs experienced in the second fiscal year preceding the fiscal period when the charges are made exceed the limit set by the Secretary. In addition, the excess charges cannot exceed the customary charge; the Secretary must advise the public of the excess charge; and the provider must notify the patient in accordance with regulations to be published. These conditions which must be met before the excess can be made would be adequate protection of the patient without the additional expense of redetermining the actual cost during the period the services were provided and making the proposed reduction.

Section 225—Limits on Payment for Skilled Nursing Home and Intermediate Care Facility Services

The average per diem costs for skilled nursing homes and intermediate care facilities countable for Federal financial participation under Medicaid would be limited to 105 percent of such costs for the same quarter of the preceding year.

With respect to both skilled nursing homes and intermediate care facilities, the Secretary is authorized to increase the specified percentage limitation to take account of increases in per diem costs which result directly from increases in the Federal minimum wage or from other changes in Federal law.

This provision inserted in the House Bill by the Administration is unrealistic and unfair. During the 4-year period February 1, 1968 to February 1, 1972, nursing homes (and hospitals) have been required to increase their minimum wages 15 cents an hour each year for a total of 60 cents an hour. Increases in the minimum wage always automatically result in similar or larger increases in the wages of employees above the minimum.

During this 4-year period no state has increased nursing home rates to providers to cover this 60¢ plus increase in the hourly rate. In fact many states have decreased or cut nursing home rates during one or more years during this 4-year period.

It is unfair to freeze nursing home rates at 5% increase when (1) the increases in minimum wages of 60¢ an hour and (2) increases in other costs brought about by inflation and other causes have not been provided for. It is discriminatory to force a 5% freeze on nursing homes and not on other providers.

On August 16, 1971, since the passage of H.R. 1 by the House, a freeze on all increases in rates has been instituted. In addition to the establishment of a Cost of Living Council and a Wage and Price Board, a Health Services Industry Committee has been appointed which came up with guidelines for increases in the health industry. The White House has also announced that control of health care costs may well be continued long after controls are taken off of the rest of the economy. Section 205 is not only confiscatory, unfair and discriminatory but is not needed.

Section 226—Payments to Health Maintenance Organizations

Medicare beneficiaries could choose to have all covered care, except emergency services, provided by a *health maintenance organization* (HMO.) HMO's are defined as public or private organizations which—

(1) provide, directly or through arrangements with others, health services to enrolled individuals on a per capita prepayment basis;

(2) provide to enrolled individuals, either directly or through arrangements with others and through qualified providers of services, all of the services and benefits covered under parts A and B of Title XVIII;

(3) provide physicians' services directly through physicians who are either employees or partners of the organization or under arrangements with one or more groups of physicians organized on a group or individual practice basis which is (or are) reimbursed for services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physicians in any such group are paid on a fee-for-service or individual practice basis;

(4) demonstrate to the satisfaction of the Secretary proof of financial responsibility and capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically;

(5) subject to the provision of the new section 1876(h), have enrolled members at least half of whom are under age 65;

(6) assure that the health services required by its members are received promptly and appropriately and that the services received measure up to quality standards which it establishes under regulations prescribed by the Secretary; and

(7) have an open enrollment period at least once every year under which they accept eligible individuals, without restrictions, except as may be provided in regulations, on a first-come first-accepted basis up to the limit of their capacity.

The Department of Health, Education, and Welfare would contract with such organizations, and would reimburse them on a monthly per capita basis at a rate equivalent to 95 percent of the estimated per capita costs of Medicare beneficiaries in the area who are not enrolled in such organizations. Profits accruing to the organization, beyond its retention rate for non-Medicare members, would be passed on to the Medicare enrollees in the form of expanded benefits.

ANHA endorses the concept of Health Maintenance Organizations but expresses grave concern in two areas. First, the definition and standards concerning HMO are not spelled out and leave everything to regulations with the results as in Medicare the intent of Congress may well be thwarted.

We fear that without more consideration and an attempt to solve the problems of Medicare and Medicaid this is being sold as a panacea to cure all health care ills just as Title XIX was sold to cure the problems in Kerr-Mills and Medicare was sold as the ultimate solution to the health care problems of the elderly. Without more consideration and refinement, HMO's in three years will be right where Medicare was in the same length of time.

Secondly, profits accruing to an HMO, beyond its retention rate for non-Medicare members would be passed on to Medicare enrollees in the form of expanded benefits. This is not only unfair to non-Medicare patients but would be invalid. This allows the Department to pass on part of Medicare expense to non-Medicare patients. Congress prohibited this in Section 1861(v)(1)(A) of Public Law 89-97. Despite this SSA has passed on Medicare expenses to non-Medicare patients by its refusal to pay full "reasonable costs" or its share of the cost of Utilization Review, preparation of cost statements and many other areas.

Section 228: Advance Approval of Extended Care and Home Health Coverage under Medicare Program.

The section established procedures for advance approvals of additional types of care after discharge from a hospital. The proposal provides a partial solution to one of the major problems experienced by Extended Care Facilities participating in the Medicare program. Retroactive denials by fiscal intermediaries, in accordance with the Department's definitions of medical eligibility, have resulted in the establishment of strict admission requirements, which, in effect, deny eligible patients the care to which they are entitled. Physicians have tended to retain patients in hospitals, where there is greater certainty of Medicare reimbursement. Much more could be said concerning the problems that this proposed amendment is designed to cure, but we will simply say that this section, combined with the Professional Standards Review Organization proposed by Senator Bennett, will insure that patients are placed in institutions providing the level of care appropriate to their medical needs.

ANHA recommends the adoption of Section 228. We believe the proposal should apply to the Medicare program as well. In order for the full benefits to be achieved, the section should be amended to include advanced approvals of skilled nursing home admissions from hospitals under Title XIX (Medicaid).

Section 229: Authority of Secretary to Terminate Payments to Suppliers of Services

The section permits the Secretary to discontinue payments to providers that abuse the program. The American Nursing Home Association has consistently stated that individuals and institutional providers which abuse the program should be identified and their participation in the program terminated. If this approach to the problem of abuse had been rigorously followed rather than the common practice of publishing more regulations, which usually results in onerous burdens and administrative costs, the patients, the provider and the program would have benefited.

Our only concern with the proposal is that deliberate abuse not be mistaken for honest errors and human misunderstandings because of the morass of confusion that has surrounded both programs.

We recommend that Subsection A on page 110, line 18, be amended to read "(A) has made knowingly, or knowingly caused to be made, any false . . . etc." The same amendment should be made on page 113, line 19.

Section 233: Amount of Payments Where Customary Charges for Services Furnished Are Less Than Reasonable Cost

This section limits payments to the amount of the provider's customary charges. The American Nursing Home Association has no objections to limiting payments to Extended Care Facilities under Title XVIII or Skilled Nursing Homes under Title XIX to customary charges established by the owners or administrators for private paying patients for similar services. The bill should be amended to clarify that rates established by governmental programs are not considered customary charges.

Section 234: Institutional Planning Under Medicare Program.

Requires facilities to have a three-year financial plan for capital expenditures and an annual operating budget of income and expenses. The objective requiring approval of capital expenditures, is clear; and, although it is contrary to some of the basic principles of the free enterprise system, the American Nursing Home Association and its members understand the rationale underlying the proposal. The Association also recognizes the desirability of any business enterprise operating under modern management principles having a financial budget including both operating and capital expenditures. However, we seriously question the advisability of requiring a facility to have a financial plan as a condition of participation in Medicare.

A financial plan is a highly sensitive document in any business, and the revelation of its contents could have adverse effects. The enforcement of the proposal would require availability for study by representatives of certifying agencies, with the consequent possibility of its confidentiality being compromised.

Sources for capital funds vary, but in most cases, negotiations for capital investments and loans are kept confidential until final commitments are made. It would be unusual that a three-year capital expenditure budget could indicate the specific sources of funds. Companies which rely on public sales of stock

may be restricted by Security and Exchange Commission rules from making financial plans available for inspection by representatives of state certifying agencies.

The proposed requirement and the actions necessary for its enforcement would be an unwarranted invasion of privacy that cannot be justified by the rather altruistic motive of attempting to force health care institutions to adopt the common management practice of developing financial plans. ANHA recommends that Section 234 be deleted.

Section 237: Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs.

The proposal to require the same or similar utilization review requirements for "skilled nursing homes" under Title XIX as that required by Title XVIII is supported by the American Nursing Home Association. Many states are already requiring utilization review, and large numbers of nursing homes have established utilization review teams voluntarily. Nursing homes normally do not have a medical staff and have established a variety of forms of utilization review. There is a consensus that the most effective forms are those which have been organized through arrangements with local medical societies. For this reason, we hope that Senator Bennett's amendment is adopted and support Section 237 as an interim step to assure the appropriate placement of patients and the provision of institutional health care in accordance with each patient's medical needs.

Section 238: Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under Medicare Program

Requires that the facility be advised when the utilization review team determines that a patient does not need the services being provided and that payment be terminated. Utilization Review programs in Extended Care Facilities have included notifications when any case is reviewed, and a determination is made that the patient does not need the level of care being provided.

The American Nursing Home Association recommends the adoption of Section 238, with the additional recommendation that the section be applicable to the institutional providers under the Title XIX program.

Section 251: Physical Therapy Services under the Medicare Program

The American Nursing Home Association is concerned particularly with the proposed provision which would limit the cost of physical therapy service to the amount equal to the salary which would be paid if they had been performed under an employment relationship. Non-hospital based Extended Care Facilities normally provide therapy services through arrangements with therapists rather than by employment of full-time therapists. In general, the amount of therapy required does not warrant the employment of a therapist as a member of the staff. Under these circumstances, the therapist continues to have the same costs for the maintenance of his office and therapy facility. In addition, the therapist has the added cost of traveling to the patient and the time away from his office practice.

Limiting reimbursement to the Extended Care Facility to the salary level of an employed therapist rather than reasonable charges will result in the facility absorbing the difference or reducing the payment of the therapist. A reduction in payment to the therapist would result in the therapist terminating the arrangement with the facility. The Extended Care Facility would be unable to obtain therapy services for its patients and would be unable to continue in the program. Adoption of this particular provision of Section 251 probably will eliminate the participation of large numbers of Extended Care Facilities in the Medicare program.

Section 254: Inclusion Under Medicaid of Care in Intermediate Care Facilities

Provisions of this section with some modifications were accomplished by the passage of P.L. 92-223 on December 28, 1971 and subsequently signed by the President. The principle provisions of P.L. 92-223 came from Section 254 in H.R. 1. ANHA supported the intermediate care amendments adopted in 1964. It is our belief that the Senate Finance Committee in adopting the amendment in 1967 intended that nursing service would be required in Intermediate Care Facilities. The Medical Services Administration of HEW promulgated regulations in August 1968 which required that the state plan provide for a level of care in Intermediate Care Facilities which provided nursing service by a licensed practical nurse. If the state plan provided for a level of care with nursing service, then the state

should provide for another level of care without nursing service. Sometime thereafter, the MSA issued another set of regulations in which they left the entire matter up to the states. As a result of this, several states have adopted the Intermediate Care program without requiring any nursing service. In many instances these states have transferred large numbers of patients from skilled nursing service, to Intermediate Care Facilities which have no nursing service.

ANHA strongly believes that P.L. 92-223 should be amended to provide (1) a class or level of care which requires at least the presence on the day shift of a licensed practical or a licensed vocational nurse, and (2) one or more levels of care which do not require nursing service. If two levels of care are provided without nursing service, in addition to the level of care with nursing service, it is our belief that the lower level of care without nursing care should allow supplementation by the family or friend.

IV. ADMINISTRATION AND JUDICIARY REVIEW

Administrative Review

Section 243: Provider Reimbursement Review Board.

We believe that the Provider Reimbursement Appeals Board established by Section 281 of H.R. 17550 should be substituted for Section 243 of H.R. 1. That section was worked out in conferences between representatives of the Bureau of Health Insurance, Senate Finance Committee staff and representatives of the American Nursing Home Association at the direction of the Senate Finance Committee.

It provides for an appeal where a provider is dissatisfied with the final determination of the fiscal intermediary, or where the provider has been unable to obtain such a determination within 90 days of filing the required cost reports. That section also allows the filing of the class actions by groups of providers providing the total amount in controversy aggregates \$10,000 or more.

The provision in H.R. 1 does not cure the problem where the provider is unable to obtain a final determination from the fiscal intermediary, nor does H.R. 1 provide for class actions. H.R. 1 requires that a provider must have a claim in the amount of \$10,000 or more. A great deal of thought and effort went into the Senate amendment and it does not seem that this provision should now be lightly tossed out in favor of section 243 of H.R. 1 which meets few of the problems and does not give the provider adequate administrative review.

Judicial Review

Medicare

Medicare is the only major government program where government is regulating an industry or field (and also procuring all of government's requirements from the provider that it is regulating) where the rules, regulations or other actions of the government agency is not subject to administrative or judicial review.

In *Aquavella v. Finch* (the Glen Oaks Case), 306 F.Supp. 860, 863, W.D. N.Y., 1969), Judge Henderson, June 30, 1969, the Court held that a "provider" of services under the Medicare Act can bring an action for judicial review of a determination of the Secretary in two instances ONLY, (1) where the Secretary determines that the provider is not eligible to participate in the Medicare program, and (2) where the Secretary terminates the provider's contact and holds the provider not to be further eligible. To the same effect are several other Federal court decisions.

The Medicare Act requires that in promulgating regulations (1) that the Secretary (a) consult with national organizations and (b) refer the proposed regulations to the Health Insurance Benefits Advisory Council (HIBAC), and the Administrative Procedure Act requires (2) that the proposed regulations be published in the Federal Register, and (3) comments solicited before it is finalized, codified and enforced.

The original "Conditions of Participation for Extended Care Facilities," as well as the original "Principles of Payment" went through this required process. However, during the past 3 years, over 1,000 state agency letters, intermediary letters and other instructions, written and oral, have been promulgated, drastically modifying the "Conditions of Participation and Principles of Payment," and with few exceptions, they have not been issued pursuant to the due process requirements of the Medicare Act or the Administrative Procedure Act.

In other words, the industry or national associations were not consulted, the proposed changes were not referred to HIBAC and were not published in the Federal Register for comments before implementation. To add to such arbitrary action, countless important changes and amendments were made retroactive for periods in excess of two years.

By contrast, actions of the Defense Department adversely affecting a government supplier are subject to review by the Armed Forces Board of Contract Appeals as well as by other Boards of Contract Appeals. The Defense Department does not begin to regulate its government suppliers to the extent that the Department of Health, Education and Welfare and the Social Security Administration do. Yet it has a review process. In addition, it should be noted that the Medicare Act gives the Secretary more discretionary power to issue rules and regulations than in almost any other piece of Federal legislation. Certainly, some review of his actions should be allowed, especially since he has delegated so much of his authority to the Social Security Administration as well as to the various divisions of the Department such as the Medical Services Administration and others.

Judicial Review Allowed Under State Welfare Acts

The Administrative Procedure Act of almost every state allows judicial review of actions of the State Health or Welfare Commissions. Recently, the Court of Appeals for the State of California (Third Appellate District) in *California Association of Nursing Homes v. Spencer W. Williams, Administrator of the Health and Welfare Agency of California*, Cal. App. 2d, March 24, 1970, held that a provider in California could sue the state where the state agency had not followed procedural due process in fixing reimbursement rates for nursing homes.

In *Catholic Medical Center of Brooklyn v. Rockefeller*, (U.S.D.C.E.D.N.Y.), No. 69-C-641, 305 F. Supp. 1268 (1969), a three judge statutory composed court (required because constitutionality of state law was raised) held two hospital providers under Title XIX could maintain an action against the State of New York where the "State Plan" and state law were in conflict with Title XIX of the Social Security Act as amended.

Judicial Review Allowed Under Title XIX

It seems anomalous that the Federal Government should not allow judicial relief in a section of an area where most states do, and even where the Federal Government allows it in all other sections of the area.

In a procurement situation where the agency acts as legislator, prosecutor, judge and jury all combined, without any restraints except its own, arbitrary action is not discouraged.

When ANHA proposed in 1970 that Medicare providers should be accorded judicial review as all other government providers are and no longer be treated as second class citizens, HEW raised the time worn arguments that are always raised when it is suggested no government offices or agency should possess unlimited power without the courts looking over their shoulders.

These two arguments of HEW against full judicial review are that (1) there is no provision for administrative review therefore judicial review cannot be granted and (2) this will open the floodgates of litigation and clog the Federal courts. As to the first argument, an administrative review mechanism in Section 281 of H.R. 17550 has now been worked out which should be substituted for Section 243 of H.R. 1. When someone used the argument of "opening of the floodgates of litigation" on Mr. Justice Oliver Wendell Holmes, he retorted that this did not impress him as it would not happen as long as the Supreme Court sat, and in any event, that was the reason he was there.

To say that providers, by class actions or otherwise, having controversies of \$10,000 or more is going to clog the courts, when every welfare recipient has the right to judicial review is a little ridiculous.

Many of the arbitrary regulations under Medicare could have been corrected in the first two years of the Act had judicial review been provided for. Attached hereto as Appendix B is a copy of the Federal Courts Decision in *Sowell v. Richardson* rejecting SSA's regulations on non-covered care. The Federal Courts can be a great aid to the Congress in assuring that Medicare beneficiaries obtain the benefit Congress in assuring that Medicare beneficiaries obtain the benefit Congress intended them to have and at the same time assure fair treatment of the providers.

Accordingly, we propose that direct suits against the Secretary be allowed to be brought in the United States District Court where the facility or provider is

located or in the United States District Court in the District of Columbia and where the amount of the claim or class action is \$10,000 or more and has been pending for 90 days. (See Appendix A for the suggested amendment to the Social Security Act.)

Rule Making—Hearings on the Record

In general, rule making is a major aspect of the total government process. The fact that it is a function of the administrative branch of government does not alter the fact that rules and regulations are law. Therefore, rule making should be effected through careful and deliberate consideration of the facts involved and responsible decisions of those facts. The enormity of the task requires some reasonable categorization under which less substantive rules may be adopted through a relatively simple process. Rule making involving more substantive factors such as property rights should require processes which provide greater opportunity for presentation of facts and a more formal record of the process. The rule making implementing the Medicare program has been less than satisfactory.

The record of the adoption of the rules on "reasonable cost" is an example. In almost every instance where the local, state or federal government files a rate, other than a negotiated rate, for which the government or the public has to pay for a service or commodity, the rate is required to be fixed after a public hearing on the record.

This is true in connection with public utility rates, railroad, bus and trucking rates, airline fares, stockyard rates and many others. In fact, it was the hearings on stockyard rates that produced the decisions of the United States Supreme Court in the four *Morgan Cases* which became the foundation for the Federal Administrative Procedure Act.

The Medicare Act does not require a hearing in connection with the development of the "reasonable cost" formula. It requires that it be reviewed by the Health Insurance Benefits Advisory Council. However, HIBAC avails itself of the HEW Staff and utilizes the HEW General Counsel's office for legal and other advice so that it is not wholly independent of the Secretary. When HIBAC made its recommendation for the first reasonable cost formula, it relied in part on the then General Counsel and staff who advised that the law did not allow a return on investment or cost of capital factor for proprietary extended care facilities. This opinion was contrary to all professional legal and accounting advice including the opinion of the General Accounting Office later obtained by the Senate Finance Committee in a report dated May 24, 1966. The minutes of HIBAC were restricted and no one knows for certain what facts or factors HIBAC or the Secretary relied upon in approving the reasonable cost formula developed by the HEW staff members (the same staff members that advised HIBAC).

A large number of formulas for reimbursement by states under Title XIX require that the rate to be fixed after notice and hearing. This is the only fair, reasonable and legal approach. Otherwise there is no reasonable opportunity to form a record on the basis of which a reasonable rate can be fixed. There is no adequate means of questioning the facts or factors (which are unknown) considered by the HEW staff in the rate which they recommend to the Secretary. This is contrary to American Administrative Law principles of fairness.

The American Nursing Home Association recommends that rule making on Section 1861 of the Social Security Act include adequate notice, opportunity for hearing and participation by providers and other affected parties. (See Appendix A for a suggested amendment to the Social Security Act.)

Definition of "spell of illness" under medicare

Section 1861(a) defines "spell of illness" as commencing with the first day a patient enters a hospital, uses his hospital and/or extended care benefits, and ending 60 consecutive days thereafter, on which he is neither an in-patient in a hospital or an extended care facility.

An "extended care facility" for the purposes of "spell of illness" was defined by Congress in section 1861(j)(10) as a facility "which is primarily engaged in providing to in-patients (a) skilled nursing care and related services for patients who require medical or nursing care, or (b) rehabilitation services for the rehabilitation of the injured, disabled or sick persons." Although Congress specifically defined an "extended care facility" for the purposes of "spell of illness," the Social Security Administration had radically altered the Congressional definition, in effect preventing many thousands of beneficiaries from ever ending a spell of illness, or really ever having a second coverage under Medicare.

The Social Security Administration has done this by defining an "extended care facility" as a facility which is under supervision of a licensed practical nurse—who need not be a graduate of a State approved school—with aides, orderlies, or attendants on the other two shifts. One example will best illustrate the hardship. Patient A is a man 75-years-old and living in a custodial home, a typical retirement type home, of which we have many in this country. He can get around, but he needs someone to make sure that he eats his meals and takes his medicine. Patient A has a severe heart attack. He enters the hospital for 90 days. He is then transferred to an "extended care facility" for 100 days. He returns to the custodial home, the retirement home, his original point of origin, where he has lived for 2 years. He can never again become eligible for medicare benefits under letter No. 65 because there is 8 hours a day of "nursing service" available in that retirement home. This residential care home is considered by the Social Security Administration to be an extended care facility solely for the purpose of not breaking his "spell of illness," or granting him another benefit period. In effect, if he falls down the stairs 6 months later and breaks a leg, it is just too bad. He is not possibly covered again under these conditions.

State agency letter No. 65 makes one's Medicare benefits hinge on his station in life or on the circumstances under which he is living at the time he enters the hospital. The result is that the individual who needs Medicare benefits the most is denied them. (See Appendix A for suggested amendments to the Social Security Act.)

This concludes our testimony, Mr. Chairman. We thank you and the members of the Committee for the opportunity of presenting the views and recommendations of the American Nursing Home Association.

APPENDIX A

ANHA's : PROPOSED AMENDMENTS TO TITLE XVIII OF THE SOCIAL SECURITY ACT AS AMENDED

(Public Law 89-97 as amended)

I. Amend Section 402¹ of the Social Security Act as amended to give the Secretary broader authority to experiment with true incentive plans in connection with the reimbursement of extended care facilities by adding a new Section 402(d) at the end of the Section 402(c), striking out the period and inserting a comma and the word "or."

"(4) Under a plan developed under Title XVIII or Title XIX of such Act, and which are selected by the Secretary in accordance with regulations established by the Secretary, could be reimbursed or paid in any manner mutually agreed upon by the Secretary and the extended care facility."

"The method of payment of reimbursement to post hospital extended care facilities, whether on the basis of a state, region, fiscal intermediary or facility or a portion thereof,¹ which may be applied in such experiments shall be such as the Secretary may select and may be based on charges, costs, a flat rate or a negotiated rate, or any other concept, adjusted by incentive factors, which may reward the provider by sharing the savings of costs or projected cost, increases or projected increases of costs or by the payment of a fixed fee or some other method and may include specific incentive payments or reduction of payments for the performance of specific actions but in any case shall be such as he determines may, through experiment, be demonstrated to have the effect of increasing the efficiency and economy, or either, of health services through the creation of additional incentives to these ends without adversely affecting the quality of such services."

II. Amend Section 205 of the Act to allow providers of service to sue the government directly for claims in excess of \$10,000 by adding a new subparagraph to Section 205(h) as follows:

"(h) Notwithstanding any other provisions in this title, any provider of services whose claims, directly or indirectly, under any section of Title XVIII

¹Technically, the underlined part is an amendment to 42 U.S.C., Sec. 1395(b)(1)(a). This paragraph (as unamended) was enacted as a part of the Social Security Amendments of 1967 (Public Law 90-248, Title IV, Sec. 402(a)) and not as a part of the Social Security Act.

(whether it be for benefits denied any individual under Part A or Part B for which such provider has furnished care or services or for other reimbursement, including but not limited to the cost of administering such title or both) aggregates \$10,000 provided such claim has remained unpaid by the fiscal intermediary or by the Secretary for a period of ninety (90) days shall be entitled to bring an action against the Secretary under Section 1331 of Title 28 of the Judicial Code of the United States without further exhausting available administrative remedies, for damages or injunctive relief, in the United States District Court in any district in the State in which the provider of services is located, or the United States District Court for the District of Columbia, and service of process on a Regional Director of the Department of Health, Education, and Welfare shall be considered service on the Secretary."

III. Amend Section 1812(a) (1) and (2) regarding "Scope of Benefits" to reduce hospital days and extended care days to 50 days and to read as follows:

"Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf (subject to the provisions of this part) for—

"(1) inpatient hospital services for up to 50 days during any spell of illness,

"(2) post-hospital extended care services for up to 50 days during any spell of illness."

IV. Amend Section 1812 to provide for an additional 50 days of hospital or extended care for a catastrophic illness or new diagnosis by adding a new paragraph (g) to read as follows:

"1812(g) Notwithstanding any other provisions of this title, inpatient hospital services for up to an additional 50 days and post-hospital extended care services for up to an additional 50 days shall be allowed for a catastrophic illness or for a new diagnosis that developed or was discovered for the first time in the hospital or extended care facility provided such a finding has been made or confirmed by the physician members of the Committee or group, as described in Section 1861(k)."

V. Amend Section 1861 (a) (2) in regard to "Spell of Illness" to require a 90-day period in which they were neither an inpatient in a hospital or extended care facility and giving the term "extended care facility" the same meaning as it has in the remainder of the Medicare Act.

"(2) ending with the close of the first period of 90 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility under *Title XIII*.

(b) Amend the last paragraph of section 1861 (j) by deleting the phrase in parenthesis and the sentence after subparagraph (10) as follows: "(other than for the purposes of section (2) (2).)" "For purposes of subsection (a) (2), such term includes any institution which meets the requirements of paragraph (1) of this subsection."

VI. Amend Section 1862 (a) to provide for a further definition of custodial care by Congress by adding the following to Section 1862(a) (9) and the following new subsection 1862(a) (13) to read as follows:

"1862(a) (9) Where such expenses are for custodial care. However, the first 10 days in an extended care facility are not to be considered custodial care, and in any event, the term, "custodial care" does not constitute any of the following: (1) observation an assessment of total needs of the patient or (2) planning, organization and management of a treatment plan or (3) rendering of direct services to a patient where the ability to provide the services requires specialized training or (4) in the case of psychiatric disorders that are primarily organic and neurological in origin."

"1862(a) (13) where the only service rendered in the hospital is skilled nursing care and/or some other service that can be rendered in an extended care facility."

VII. Amend Section 1871 of the Act by adding the following paragraph thereto:

"Notwithstanding any other provisions of the Act, rules and regulations promulgated by the Secretary pursuant to the provisions of Section 1861 shall not become effective unless and until adequate notice, opportunity for hearing and participation by providers or other affected parties is provided."

APPENDIX B

26,215 INTENT OF MEDICARE LAW—APPLICATION OF CUSTODIAL CARE
EXCLUSION TO ECF SERVICES

Charlie D. Sowell, Administrator of the Estate of Myrtie W. Sowell, Deceased v. Richardson, U.S. District Court, District of South Carolina, Florence Division, Civil No. 70-583, filed Nov. 19, 1970.

Noncovered care in ECF—Intent of Congress—Requirement that ECF stay be related to prior inpatient hospital stay.—The legislation that created the Medicare law is remedial and should be liberally construed to effectuate its purpose of insuring that adequate medical care be made available throughout the country, and neither the courts nor the Secretary should, in the interest of minimizing costs, interpret the law in such a way as to frustrate its purpose. Accordingly, a decision of the Secretary denying benefits for an ECF stay on the grounds that the conditions treated in the ECF were not related to those for which the patient was hospitalized, and that skilled nursing services were not required, is reversed. Every aspect of the patient's condition must be considered in determining whether the services are covered or not, and not just the services actually rendered. Therefore, where the beneficiary's general condition was such that she required skilled nursing care—she was dying of terminal cancer, complicated by diabetes and emphysema, when admitted to the hospital, but the immediate cause of her hospital admittance was an attack of dyspnea not actually treated in the ECF—and a letter from her doctor stated that she had been prematurely discharged from the hospital and that she required constant care, she could not be denied benefits under the custodial care exclusion. *Back references:* ¶ 1309, 4115.

[TEXT OF DECISION]

HEMPHILL, District Judge: This action was instituted by Charles D. Sowell as the Administrator of the estate of his deceased wife, Myrtie W. Sowell, for hospital insurance benefits provided in Section 1812 of the Social Security Act (hereinafter referred to as "the Act") (42 U.S.C. 1395d).

Section 1869(b) of the Act (42 U.S.C. 1395ff(b)) provides for judicial review of the final decision of the Secretary of the Department of Health, Education, and Welfare (hereinafter referred to as "the Secretary") when the amount of hospital insurance benefits in controversy is \$1,000 or more. The final decision of the Secretary in this case consists of a decision rendered by a Hearing Examiner in the Bureau of Hearings and Appeals in the Social Security Administration, Department of Health, Education, and Welfare on March 6, 1970, as affirmed by the Appeals Council of this Administration on May 8, 1970. This decision held that the plaintiff's deceased wife, Myrtie Sowell, was not entitled to have hospital insurance benefits paid on her behalf to the Hartsville Convalescent and Nursing Home for services provided Mrs. Sowell during her stay at the Home from September 24, 1969: that the services were not "extended care services" as defined by Section 1861(h) of the Act (42 U.S.C. 1395x(h)) but instead constituted "custodial care" and therefore were excluded from coverage under Section 1862(a) (9) of the Act (42 U.S.C. 1395y(a) (9)).

The nature of the judicial review authorized by Section 1869(b) of the Act is governed by the provisions of Section 205(g) of the Act (42 U.S.C. 405(g)). Section 205(g) of the Act, in turn, provides, *inter alia*, that "As part of his answer the Secretary shall file a certified copy of the transcript of the record, including the evidence upon which the findings and decision complained of are based," and that "the court shall have power to enter upon the pleadings and transcript of the record, a judgment affirming, modifying or reversing the decision of the Secretary, with or without remanding the cause for a rehearing." It also provides that "the findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive." Subsection 205(h) of the Act, 42 U.S.C. 405(h), (made applicable to actions under Title XVIII of the Social Security Act by Section 1872 thereof, 52 U.S.C. 1395ii), expressly restricts the judicial remedy to the aforesaid manner of judicial review.

[FACTS]

The beneficiary, Mrs. Sowell, was entitled to hospital insurance benefits as provided for in Section 1812 of the Act (42 U.S.C. 1395(d)). On September 18, 1969, at age 72, she was admitted to the Byerly Hospital, Hartsville, South

Carolina, following an acute attack of shortness of breath. The medical evidence as summarized in the patient's discharge summary from Byerly Hospital on September 24, 1969 indicates that Mrs. Sowell had a left radical mastectomy performed in May 1968. Clinical evidence in June 1969 demonstrated metastatic spread of the cancer and all concerned knew of the terminal nature of the illness. Diabetes mellitus was diagnosed also in June 1969. In addition to the attack of shortness of breath, the patient had complained of swelling in the right lower extremity. Chest x-ray revealed the presence of early pulmonary emphysema. Her course in the hospital was uneventful and she was discharged on September 24, 1969. The discharge diagnosis was:

1. Carcinoma of the left breast, 1½ years postoperative with widespread skeletal metastases;
2. Diabetes mellitus, mild to moderate in severity;
3. Cataract senile, O. S.;
4. Pulmonary emphysema

Upon discharge from Byerly Hospital, the patient was transferred to the Hartsville Nursing and Convalescent Home. The transfer form signed by Dr. K. W. Krueger indicated that the patient's activity tolerance limitations were moderate to severe, full weight-bearing was possible, and the patient was permitted to sit in a chair for one hour three times daily.

This court in considering this matter realizes that it is of concern not only to the plaintiff herein but also to the defendant. If care of the type indisputably provided the deceased herein is in fact, and was intended to be covered by the Act, the defendant can expect very substantial expenditure regarding similar claims. It is not disputed that the institution in which the deceased was maintained is in all respects qualified as an extended care center or that she was admitted after a period of hospitalization on the proper certificate of her physician.

[DISCUSSION]

The exclusion upon which the Secretary relies bars payment of expenses for "custodial care." (42 U.S.C. Section 3959). This court finds no authority defining "custodial care" as used in the statute. The position of the Secretary is that benefits can be paid for treatment in an extended care facility only if the treatment provided is such that it must be given under the supervision of a registered professional nurse. Further explanation of extended care is found in the Government's brief where it is urged that they include health services which can *only* be provided in an institutional setting by trained and skilled professional personnel. Likewise, the services must be an extension of the medical treatment the beneficiary received in a hospital. The Secretary urges that care which fails to meet this standard is "custodial" and therefore compensation for it is not authorized.

This court does not find justification in the Act for such restrictive definition of the extended care provisions. The legislation which created health insurance for the aged is remedial and therefore to be construed liberally to effectuate the congressional purpose. See *Walston v. Gardner*, 381 F. 2d 580 (6th Cir. 1967). The purpose of the Act was to insure that adequate medical care was available to the aged throughout this country. (See 1965 U.S. Code Cong. & Admn. News, p. 1964). Neither the courts nor the Secretary should, in the interest [of] minimizing costs, so interpret the provisions of the Act as to frustrate its purpose. A sensible nontechnical approach to interpretation of this chapter is necessary in order to give effect to the purposes of the Act and to afford equitable treatment to those seeking its benefits. (See *Posquale v. Cohen*, 296 F. Supp. 1088, (D. R. I. 1969)).

The position taken by the Secretary is not in accord with these principals [sic]. Under his formula for determining whether the services are covered only the service actually rendered is considered. The condition of the insured and manifest symptoms of the illness are in his view only relevant to the extent that they determine the treatment administered. Were the law as contended by the Secretary, consideration of the trees is commanded but even a glimpse of the forest prohibited. It was never intended by Congress that the condition of the insured, treatment that might at any time be necessary, and the pain and discomfort attending inadequate or unprofessional care or lack of care not be considered together with treatment actually provided in determining whether extended care services are justified. Every aspect of the plaintiff's physical condition must be considered in making the determination. Treatments immediate-

ly required are of course a major factor. However, even if no treatment were required the condition of the insured might be so unstable or unsatisfactory, as to require the extended services contemplated by the statute. Regardless of the proper standard for evaluation [of] services for the purpose of determining their coverage under the Act, the record in this instance convinces the court that all the evidence indicates that the care given the insured was contemplated and compensated through the Act.

It appears that the immediate problem requiring the period of hospitalization of the insured was an acute attack of shortness of breath. The defendant reasons that, because that symptom did not require treatment either in the hospital or the extended care facility, the admission of the insured to the latter was not for the same malady as to the former. It is argued that the necessary sequential element of treatment is lacking. The argument is without merit. The lady was dying of cancer, complicated by diabetes and emphysema at the time of her admission to the hospital. The only reasonable inference is that the attack of dyspnea, which was the immediate cause of the admittance to the hospital, was a result of the general physical condition of the insured. When admitted to the extended care facility the pitiable condition of the insured had not improved but was the same that had required her initial hospitalization.

[SUBSTANTIAL EVIDENCE QUESTION]

The only remaining question is whether the record contains substantial evidence for the Secretary's finding that the care Mrs. Sowell received was not that of the skilled type contemplated by Congress. The lady's physician by letter indicated the dire nature of her problems,¹ and stated that she was prematurely discharged from the hospital to the extended care institution. It appears that she could do nothing for herself and required assistance to perform any function. The treatment ordered included a diabetic 1800 calorie diet, substantial doses of medications of various sorts and daily urine analysis. While it may be true that this could have been accomplished in a less sophisticated setting, it must not be overlooked that the lady's condition was extremely unsatisfactory and deteriorating. That she required observation was evidenced by the recent attack requiring her hospitalization. By February 1970 she had to be catheterized and on March 2, 1970 she died. There is no evidence in the record that her admission to the extended care facility in late September 1969 was not required by her need for skilled medical attention. All the evidence indicates that she was in terrible physical condition and that she in fact required the care offered by the institution.

Therefore the decision of the Secretary must be reversed and judgment entered for the plaintiff.

And it is so ordered.

26,216 PROPOSED MEDICAID REGULATION CHANGE REQUIRING SCREENING, DIAGNOSIS, AND TREATMENT OF PHYSICAL AND MENTAL DEFECTS FOR INDIVIDUALS UNDER 21

PROPOSED REGULATION, 35 F.R. 18878, DEC. 11, 1970

Early and periodic screening, diagnosis, and treatment of physical and mental defects for individuals under 21.—A proposed Medicaid regulation amendment

¹ The letter of Dr. Kreuger was as follows :

"OCTOBER 3, 1969.

"Dear Mrs. Grooms :

"This is written in response to the denial of extended care for the above patient of mine. "Mrs. Sowell has terminal carcinoma which has recently (about four months ago) been complicated by diabetes mellitus. Widespread skeletal metastasis due to breast carcinoma is present. Nodules can be felt on the skull surface and there is widespread lymphatic metastasis manifested by moderate lymphedema of the right lower extremity. Stilbesterol, fortunately, has moderated, to an extent, these dreadful complications of the skeleton and accompanying pain.

"Mrs. Sowell was in the hospital under the Medicare program and was prematurely discharged to an extended care institution. Denial of benefits under the program makes this decision regrettable.

"Denial of benefits to this patient would indicate the exclusion of those sorely in need of constant care. This patient is unable to walk or care for herself in any way.

"Whereas I regret that I have found questionable some of your decisions regarding the need for hospitalization or extended care, in this particular case, I must strongly voice my objection to your decision that there is not a need for extended care. I must ask for a reversal of this decision."

"Sincerely,

"(s) K. W. Kreuger
K. W. KREUGER, M.D."

would require state Medicaid agencies to set up administrative mechanisms to identify available screening and diagnostic facilities as well as individuals under age 21 eligible for early and periodic screening, diagnosis, and treatment of physical and mental defects. Agreements would be made with other public and voluntary agencies in order to assure full use of the services provided by those agencies. The states would have the option of making these services available either (a) to all eligible individuals under age 21 no later than January 1, 1971 or (b) to all eligible children under six years of age by January 1, 1971 and all other eligible individuals under 21 in progressive stages by July 1, 1973. *Back references:* ¶ 14,551, 21,610.

[TEXT OF PROPOSED REGULATION]

Part 249 of Chapter II of Title 45 of the Code of Federal Regulations is amended as follows:

1. Section 249.10(a) is revised by redesignating subparagraph (3)-(9), inclusive, as subparagraph (4)-(10), inclusive.

2. Section 249.10(a), as so revised, is further amended by adding subparagraph (3) to read as follows:

§ 249.10 AMOUNT, DURATION, AND SCOPE OF MEDICAL ASSISTANCE

(a) * * *

(3) In carrying out the requirements in subparagraphs (1) and (2) of this paragraph with respect to the item of care set forth in paragraph (b) (4) (ii) of this section, provide:

(i) for establishment of administrative mechanisms to identify available screening and diagnostic facilities, to assure that individuals under 21 years of age who are eligible for medical assistance receive the services of such facilities, and to provide such treatment as may be included under the State plan and as required in subdivisions (iv) and (v) of this subparagraph;

(ii) for identification of those eligible individuals who are in need of medical or remedial care and services furnished through title V grantees, and for assuring that such individuals are informed of such services and are referred to title V grantees for care and services, as appropriate;

(iii) for agreements to assure maximum utilization of existing screening, diagnostic, and treatment services provided by other public and voluntary agencies such as child health clinics, OEO Neighborhood Health Centers, day care centers, nursery schools, school health programs, family planning clinics, maternity clinics, and similar facilities;

(iv) That early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered within the limits of the State plan on the amount, duration, and scope of care and services, will be available to all eligible individuals under 21 years of age; and that, in addition, eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, will be available, whether or not otherwise included under the State plan, subject, however, to such utilization controls as may be imposed by the State agency. If such screening, diagnosis, and such additional treatment are not available by the effective date of these regulations to all eligible individuals under 21 years of age, the State plan must provide that screening, diagnosis, and such additional treatment will be available to all eligible children under 6 years of age, and must specify the progressive stages by which screening, diagnosis, and such additional treatment will be available to all eligible individuals under 21 no later than July 1, 1973.

* * * * *
The CHAIRMAN. Is Mr. Andre Maisonpierre here?

STATEMENT OF ANDRE MAISONPIERRE, VICE PRESIDENT, AMERICAN MUTUAL INSURANCE ALLIANCE

Mr. MAISONPIERRE. Thank you, Mr. Chairman and members of the committee.

My name is Andre Maisonpierre and I am vice president of the American Mutual Insurance Alliance. We are a voluntary association of property and casualty insurance companies which provide workmen's compensation, automobile, and other property and casualty coverages in all 50 States and the District of Columbia.

As property and casualty insurers, we have played an important role in financing the cost of medical care for the accidental injury. Our remarks today, however, are not limited to the traumacare financing system; rather, we want to stress the effects which S. 1376, the Catastrophic Illness Act, is likely to have on all existing medical care insurance systems. Let there be no mistake about it, catastrophic illness insurance will superimpose a governmentally operated and financed mechanism on already existing coverages.

We appreciate the opportunity of presenting our views to the committee. Since our oral statement only very briefly summarizes our full statement, we respectfully request that the full statement be made part of the record.

The CHAIRMAN. We will do this.

Mr. MAISONPIERRE. Thank you, sir.

We recognize the superficial attractiveness of S. 1376 in that it would provide protection against the high cost of specialized or long-term health care procedures. We feel, however, that the creation of a distinct financing mechanism for that phase of care would only further fragment the system and result in a greater proliferation of costly facilities and specialties at the expense of more basic needs. We would therefore urge that catastrophic health care program be a part of a total program.

As spokesman for an important segment of the private insurance industry, we support a major role for the private insurance carriers in the financing and administration of the total program. We recognize that there are certain limitations in the private system and that consideration might be given to some governmental involvement. But we are unalterably opposed to the nationalization of any segment of the health insurance industry. The enactment of a catastrophic illness insurance program operated and financed by Government would be the first step in overall nationalization.

Today we want to alert the committee to the serious impact catastrophic health insurance will have on other insurance systems, to the extent that such other systems presently pay for the costs of such care.

The enactment of catastrophic illness insurance will only further compound existing problems of shortages and maldistributions of manpower and facilities in the health care delivery system. Since the program would remove economic limitations on care, it would encourage consumers to use higher cost forms of care which are now in short supply. The cost effect resulting from this situation is of grave concern to us because it will have serious impact on our ability to exert some measure of control on the trauma care subsystem, our major area of responsibility.

The major barrier to the creation of an equitable catastrophic illness insurance structure is a definition of the term, for what is a catastrophe to one family might be only minor economic dislocation to another. Catastrophe varies with the individual; the flexibility needs to be built into the program. Fixed thresholds and other similar

mechanisms cannot possess such flexibility and in so doing present even more convincing arguments for a total program.

S. 1376 is based on presently existing private coverage. Over the range of a given illness, we would have the private insurance mechanism with its own set of controls operating during one phase, but once the cost exceeded the deductible required by the catastrophic illness plan, social security procedures would be operative. This is not as clear as it appears for while social security is administering the catastrophic plan, the private insurer under his major medical coverages may also be involved in reimbursing the deductibles. It does not take a great deal of imagination to visualize the administrative difficulties which would arise under this divided system.

The justification for the Federal Government to replace a function which has historically been assumed by private enterprise is the unwillingness or inability to fill the need through private resources. This is not applicable in this case, for the private health insurer has steadily increased his benefit packages and is presently covering more people than ever before.

Similarly, the casualty insurer under workmen's compensation is providing unlimited medical care coverages in almost every State and of late the American Mutual Insurance Alliance has urged the adoption of an automobile no-fault plan which would provide \$50,000 in protection for the automobile accident victim. The plan would cover more than 99.9 percent of the medical cost of automotive injuries.

There are other examples but there is no need to recite them here. Rather, we would urge their recognition as evidence of the insurer's concern for his social responsibility. We would express a deep concern over the limiting effect catastrophic illness insurance would have on the efforts of the private sector and on current experiments in the improvement of the health care system, one of which is the Health Maintenance Organization.

We previously stated that S. 1376 will superimpose on a number of health care financing systems. Past the thresholds of its deductibles, it will duplicate benefits provided by other systems. To the extent that there is benefit duplication, there exists an overcharge for the financing of health care, an overcharge which is not economical when one considers the aggregate costs involved.

Such duplication is to be avoided to the extent possible and all health insurance coverages must be made mutually exclusive of each other. This requires subsystems organized to allocate the total costs of care to appropriate economic units. Yet the overall system would reimburse for the total cost.

The workmen's compensation subsystem is a good example, for the full range of services needed by the employee from the time of his injury until he returns to the job are reimbursed by the insurer. In this way the costs of care are properly charged against the product or process.

The advantages of this approach are obvious, for not only are the medical care needs of the beneficiary financed as a continuum, but also the costs of care are allocated to the economic unit responsible. Thus, the basis for reasonably rational economic decisions on important individual and public policy goals is provided.

The advantage would be lost with the transfer of a portion of the costs to the catastrophic illness insurance system and, concurrently, the effectiveness of the casualty insurer in the management of trauma would lessen.

It is further suggested that the emphasis on total trauma care management, a role filled by the casualty insurer, will subside if catastrophic illness insurance displaces any part of this role. It should be against public policy to displace this specialty.

Medical benefits paid under casualty coverages fall into two broad categories: On the one hand, such benefits are paid under no-fault type insurance systems, such as workmen's compensation, automobile no-fault, et cetera. On the other hand, substantial benefits are paid under the tort liability system to reimburse medical losses incurred as a result of someone else's negligence.

As related to the tort liability system, it is suggested that if the committee ultimately recommends a national catastrophic illness insurance plan, that it be given the right to subrogate against any available tort liability benefit sources. This will allow for sufficient flexibility to insure that the individual in need of extensive medical care services will receive care at the time his need arises. However, through the subrogation mechanism, the ultimate cost of the care will be charged against the negligent party.

The subrogation mechanism is not needed, however, to coordinate national catastrophic illness insurance with other Government-mandated, first-party insurance programs. Foremost among these are the no-fault auto insurance plans which more and more State legislatures are enacting today.

There is no reason whatsoever to charge part of the cost of no-fault insurance losses to private insurance and the balance to a catastrophic illness insurance plan, especially at the levels indicated by S. 1376; and there are many reasons why the total costs of benefits need to be internalized within the automobile system.

As to workmen's compensation, this committee incorporated in the medicare law a provision barring the payment of medicare benefits to the extent workmen's compensation benefits are payable for the same condition. This provision has worked extremely well.

Does it not make more sense to first exhaust first-party, no-fault benefits and then if these benefits are not sufficient to cover the total loss fill whatever gaps remain by applying catastrophic illness insurance benefits?

Automobile no-fault coverages are but one example of this new breed of insurance protection. Within the foreseeable future, injuries associated with airline crashes may be similarly covered and even medical malpractice insurance may move in the direction of no-fault. All of these programs should bear the total costs of the losses which they generate. These programs should not be subsidized in part by a governmental program.

In conclusion, we want to reemphasize our concern at the further fragmentation of the health care financing system. This can only lead to increased cost and increased specialization. We must stress that the financing of catastrophic illness costs must be incorporated in a total medical care financing program. Furthermore, this total program must

also be coordinated with existing medical payment systems in order to avoid wasteful duplication.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Well, thanks for your statement.

I was aware that your organization was going to take that position and, of course, I am sorry to see you do that because I very much favor compulsory insurance for catastrophic illness. I regret to say I believe your organization is making the same mistake they made in the medicare fight.

There is no doubt in my mind if we didn't do something about providing compulsory insurance for the aged it was just a matter of time before your people were going to lose that fight and the Government was going to do the whole job for you.

Why should people have to pay a fee for catastrophic insurance which includes a selling cost when everybody ought to have it anyhow? Why should they have to go to the expense of carrying the cost of a sales organization in order to have something that everybody ought to be required to have anyhow?

Mr. MAISONPIERRE. Mr. Chairman, we are not opposed to the catastrophic illness coverage as such. We think that catastrophic illness protection should be part of an overall package of insurance and, as Senator Curtis indicated with a prior witness, we believe that if a catastrophic illness plan, as such, is enacted today, this will set the pattern for the future of health insurance in the country.

Now, it seems to us that this pattern should be set at least in its totality rather than coming up with a fragmented program at first and then expanding this program by reducing the deductibles and the coinsurance in the years to come.

The CHAIRMAN. Well, your people are playing the game all or nothing for private insurance and the AFL-CIO were in here testifying against catastrophic illness because they want to fight you on just exactly those terms. They figure they can beat you and prevent your program from being passed to subsidize your people at the taxpayers' expense, and that in the long run they can make this an issue in a nationwide election and hope they have the Democratic candidate in favor of national health insurance. They will just beat you the whole way and put you people out of the insurance business, even where you could make a very good case, it ought to be optional whether any person wants to carry any more insurance or not.

So that puts the two of you together for two opposing reasons. They figure they are going to win and take the whole thing over; and they fear—they have not said it, but it is obvious enough to me what the case is—they fear that if we take their best cases away from them, the cases of desperate, crying need, they are not going to be in nearly as good position to fight for national health insurance as they would be if catastrophic insurance as a part of social security went into effect.

On the other hand, your people are hopeful the Government is going to subsidize them to have everybody buy insurance with a private company, by giving them a tax credit or tax deduction, so you want to play the game all or nothing and they want to play the game all or nothing.

I predict you will find you are taking a very bad risk. If I were in the insurance business I would not insure the risk you are taking.

My guess is that if you keep us from doing anything about catastrophic illness in the long run you are going to get licked and you will wind up with the Government doing everything. But time will tell. We will just have to see how it works out.

Thank you very much.

Mr. MAISONPIERRE. Thank you, Mr. Chairman.

(The prepared statement of Andre Maisonnier and a communication of the American Insurance Association follows. Hearing continues on page 2563.)

STATEMENT OF ANDRE MAISONPIERRE ON BEHALF OF THE AMERICAN MUTUAL
INSURANCE ALLIANCE ON CATASTROPHIC ILLNESS INSURANCE

My name is Andre Maisonnier, and I am vice president of the American Mutual Insurance Alliance, the major national association of mutual property and casualty insurance companies. Our member companies provide workmen's compensation, automobile and other property casualty coverage in all fifty states and the District of Columbia. As property and casualty insurers, we have played an important role in financing health care. Our role has, however, been significantly different from that usually played by government and health insurers.

Whereas they have been concerned with the broad spectrum of health, we have had the opportunity of specializing in the management of trauma medicine. It is in our role as such managers that we address ourselves to you.

Our remarks, however, are not limited to the trauma care financing system. Rather, we want to stress the effects which S. 1376, the Catastrophic Illness Act, is likely to have on all existing medical care insurance systems. Let there be no mistake about it, Catastrophic Illness Insurance will superimpose a governmental operated and financed mechanism on already existing programs.

I. GENERAL PRINCIPLES

Although we recognize the superficial attractiveness of a program essentially designed to provide protection against the high cost of specialized health care procedures, we believe that the basic needs of the total population should not be ignored. We agree with Secretary Richardson that the enactment of catastrophic illness coverage will lead to an "even greater proliferation of costly facilities and specialties at the expense of more basic needs," and that greater fragmentation of health care and financing that we presently have should not be permitted.

It is our opinion that catastrophic health care coverages need to be included in a total program. There is no logical reason to establish such protection as a separate, and in some cases, a competing program. Most authorities agree that health care needs to be a continuum from the onset of the disabling condition to that point in time when the ill or injured is returned to society in as near to his previous condition as possible. Financing which can and does fragment this continuum is not in the public interest.

As spokesman for an important segment of the private insurance industry, it goes without saying that we urge a major role for private insurers in the financing and administration of a total health insurance program. Although we do not quarrel with some of the criticism of the existing private health insurance system, no one can overlook the fact that no other country in the world has ever developed a voluntary health insurance program of the scope presently existing in this country. The voluntary system has brought the health care benefits, which includes major and comprehensive medical care benefits, to a multitude of millions who would have had to go without had it not been for the ingenuity of the private enterprise system.

The fact that the government did not have to divert millions of tax dollars to the health field has allowed other socially desirable programs to develop. We recognize that there are certain limitations to the private system and that consideration might have to be given to some minimal government involvement. However, we are unalterably opposed to the nationalization of any segment of the health insurance field. The enactment of a catastrophic illness insurance program operated and financed through government sources would be the first step in overall nationalization.

Today, we want to alert the Committee to the serious impact which the enactment of a catastrophic illness insurance bill will have on other insurance systems—to the extent that such other systems presently pay for the cost of such cases.

II. THE IMPACT OF CATASTROPHIC HEALTH COVERAGES ON THE DELIVERY SYSTEM

It is generally conceded that there are shortages and mal-distributions of manpower and resources in the health care delivery system. Although there are any number of pending government and private proposals which would reform this system, there necessarily must be a delay before any become fully operational, and have a noticeable effect on the availability of health care services. We will continue to have therefore, for a number of years, a scarcity of services. As a result, the cost of medical care should continue to rise more sharply than other components in the cost of living index as the consumer bids for services in a comparatively scarce market.

The enactment of catastrophic health coverage would only compound this problem since it removes economic limits on care. This will encourage consumers to use higher costs form of care. For example, there would be obvious selection of extended care facilities—since these are covered—although less costly care should be provided by nursing homes whose services are not covered. This, in turn, would create demands for increasing specialization of care. Although this can mean even greater fragmentation of care then exists today, as well as greater cost, it will definitely increase the use of specialized services which are in short supply. We are concerned because this cost effect will have serious impact on our ability to exert some measure of cost control in the trauma care subsystem—our major area of responsibility in the overall health care system.

III. CATASTROPHE—DIFFICULT TO DEFINE

Probably the major problem faced by those who would create a separate program for catastrophe illness insurance, is a definition of the term. Granted equality of income other variables such as family size, the medical care needs of other family members, and a host of other factors need to be considered. A family of four living on \$20,000 per year income could perhaps expend \$2,500 on health care expenses without depriving themselves of the basic necessities.

Would a family of ten on the same income be in a similar situation? As another example, what would happen to a single man earning \$20,000, covered by a basic health program which would cover the threshold deductible for catastrophe provided in the Committee bill, when faced with a \$25,000 charge for treatment following extensive burns. With the approximate 80-20 co-insurance provisions in S. 1376, he would still be liable for about 25% of his income which may very well have ceased shortly after the onset of his disability.

It should be apparent then that catastrophe varies with the individual case, and that a great deal of flexibility needs to be built into the program. Fixed thresholds, corridors, deductibles, etc. in S. 1376 cannot possess such flexibility, and by so doing present even more convincing arguments for a total program.

IV. SYSTEMS IN CONFLICT

S. 1376 is meant to be based upon presently existing private coverages. Over the range of a given illness, we could have during the initial phase of the illness the private insurance mechanism operating with its own set of controls, but once appears however, for while Social Security is administering the catastrophic plan, Social Security procedures would become operative. This is not as clear cut as it appears however, for while Social Security is administering the catastrophic plan, the private insurer under his major medical coverages, may also be involved in reimbursing the deductibles. It does not take a great deal of imagination to visualize the administrative difficulties which could occur under this divided system. Medical care does not start and stop at various dollar levels, it makes no sense then to structure the financing system in such increments.

V. GOVERNMENT PLAN SHOULD BE EXCESS

The justification for the federal government replacing a function which has historically been assumed by private enterprises is the inability or unwillingness to fill the need through private resources. But can this rationale be applied to the

issue under consideration? The health insurance industry over the years, has continued to increase the numbers of population covered under its major medical plans. The source book of health insurance data reports that some 76,000,000 people under age 65 are covered under such insurance programs. Of this number, about 75% had hospitalization coverages of 70 days or more, or somewhat in excess of the deductibles provided in the catastrophic proposal. This we would submit is a demonstration of health insurance concerns for the long-term case, and the fact that people covered increased by over 600,000 over the 1969-1970 period would evidence the consumer acceptability of the private insurance approach.

Specifically, in the area of trauma care, the Alliance, as part of its Guaranteed No-Fault Protection Plan, is urging a \$50,000 compulsory no-fault medical care expenses coverage. According to our actuary, this would pay the medical expense of more than 99.9% of all auto accident victims.

These are but two examples of the concerns of the insurance industry for its responsibilities to society. There are others, but a recitation here would serve no real purpose. Rather, we would urge this Committee to recognize these contributions of the private sector, and to provide that any government plan be excess to existing health or property and casualty coverages.

We hope to convince the Committee that any national health insurance—whether limited to catastrophe or not—should, to the extent possible, limit itself to areas not covered by other insurance systems.

Without this there is no incentive for the private insurer to improve his programs. This will unquestionably lead to certain stagnation and an ultimate regression of the private insurance system from health care coverages.

In its report 91-1431, this Committee indicated that "the program (catastrophic health insurance) would be designed to compliment private health insurance which has played the major role in insuring against basic medical expenses."

In our opinion, the proposed catastrophic insurance program only compliments those private programs which fit into the shape outlined by the bill's deductibles and co-insurance provisions. Since it is a compulsory program it will dictate the format of the plans to be offered by the private insurer.

In essence, in a situation where it has been generally agreed that widespread experimentation with new types of payment mechanisms is necessary, catastrophic health insurance, although it would represent only about 2% of the total health care expenditure, would essentially negate this experimentation.

In the experimental area are the Health Maintenance Organizations which are in the forefront of the Administrations' program for improving the health care system. Since these, over the long run are to provide the complete range of health care services, including the catastrophic case, in its total definition and since these services are provided for a fixed monthly or some periodic payment, the impact of a catastrophic health plan could be significant.

In the first place, S. 1376, through its deductibles would tend to limit the development of the total concept which is the key to the effectiveness of cost controls and delivery efficiencies—the major attributes of the HMO according to many authorities.

We can see, for example, little incentive for the HMO to hold down costs in an identifiable potential catastrophic case when past the limits in S. 1386, financing would shift to another mechanism. And even the definition of costs here is a problem for how does one determine that the deductible for services under Part B of the program has been reached. One possible answer is the "reasonable and customary" charges for like services in the community, but is this appropriate? It has been argued by HMO proponents that the HMO produces care at less than this cost. But would this be true if the costs of services tended to rise with increased need for services, and the injection of another payment mechanism? We think the opposite would be true, and see a rise in the costs under the deductible.

We would also question a shift in responsibility from the HMO to the Social Security once the deductible thresholds have been attained. We feel this may result in a situation where services are limited to those necessary in one phase of the treatment while in the other all covered services are provided.

Over the long run, the HMO is intended to be a total health care system which would present an orderly progression from prevention through diagnosis, treatment and rehabilitation. If the HMO financing plan covers only a part of this broad spectrum, the incentive to develop the total range of care may be lost, and there may be concentration on the prevention and treatment phases, leaving the rehabilitation phase to other resources. The last phase is extremely important in the so-called catastrophic illness or injury.

VI. DUPLICATION OF BENEFITS

In our introductory remarks we stated that catastrophic health insurance will be superimposed on a number of existing systems for financing health care. Past the thresholds dictated by its deductibles, it will thus duplicate benefits provided by other systems. To the extent that there is benefit duplication, there exists an over charge for the financing of health care, an over charge which is not economic when one considers the aggregate costs involved.

It is obvious that duplication is to be avoided to the extent possible, and that health insurance coverages must be made mutually exclusive of each other. This then requires the development of a set of systems organized along the lines of the economic unit to which the total costs of care need to be allocated, and which reimburse for the total cost of the care. Such a system is represented by the workmen's compensation insurance mechanism for the total range of services needed by the employee from the time of his injury until he returns to the job are reimbursed by the carrier. In this way the costs of the care are properly allocated to the appropriate product or process.

The previously mentioned Alliance Guaranteed No-Fault Protection Plan is aiming toward a similar goal with its recommendation for a \$50,000 no fault coverage on medical care services. Except for less than one-tenth of one percent of all automobile cases, this would provide complete protection in automotive injuries.

The advantages of this approach are obvious for not only are the medical care needs of the consumer financed as a continuum, the costs of such care are allocated to the economic unit responsible. Thus, the drivers and users of automobiles would bear the total costs of automobile ownership and enjoyment, and in so doing would provide the basis for reasonably rational economic decisions on important individual and public policy goals such as:

1. How many cars should a person own?
2. How should one vote on rapid transit issues?
3. Should a person commute by car, or is mass transportation desirable and less expensive?
4. What type or make of care should be purchased from the viewpoint of both accident avoidance and protection in the event of an accident?

Isolating the total costs of automobile accidents will also facilitate the generation of sufficient statistical evidence regarding traffic accidents and their causes to maximize systematic approaches to traffic safety.

Similarly, we believe that medical benefits paid to someone injured as a result of a faulty product should ultimately be charged to the manufacturer of that product in its totality. If catastrophic health insurance were to subsidize a part of this cost, the total expense of the medical care resulting from a faulty product would not be reflected in the cost of that product, but would be borne by society as a whole. It should be against public policy to relieve negligent entities from the cost of their negligent actions. This is particularly true when those entities are commercial enterprises. Charging them with the total cost of their negligent acts creates a strong incentive for the developing of greater sophistication and care in the manufacturing and design of consumer products.

As this Committee knows, each year almost \$1-billion is paid for medical benefits alone to care for the industrially disabled. Although only a comparatively small portion of this be recognized that these benefits are paid in their entirety by employers. This creates a strong incentive for the business community to develop sophisticated programs in order to minimize not only the number of accidents, but their severity. To the extent that employers provide their employees with a healthful and safe work environment, their workmen's compensation insurance costs are reduced. On the other hand, if workmen's compensation medical benefits, and these would most probably be in the very vital area of physical rehabilitation, were to be paid by a national catastrophic health insurance system, not only would this incentive lessen, but employers would be relieved of part of the cost burden which they presently shoulder. Obviously, if employees are asked to share in the cost of a national, catastrophic health insurance, a system which would subsidize in part the costs of medical benefits arising from industrial accidents, they will be required to pay a portion of the cost of the present workmen's compensation benefit system.

The contributions of casualty insurers to the field of physical rehabilitation have been described on occasion to this Committee, and it probably is in this

area where the catastrophic insurance program would have its greatest impact.

Casualty insurers are responsible for an individual's total recovery, and I would emphasize *total*. Long ago our workmen's compensation insurers began to realize the necessity of becoming deeply committed to the rehabilitation of the industrially disabled if they were to be in a position to control disability. Hence, the traditional dedication of many of our companies to rehabilitation. Not only have our companies been mass purchasers of rehabilitation services, but they have pioneered new rehabilitation techniques which have greatly enhanced the opportunities for the disabled.

It is clear that this total involvement in the care of the traumatically injured can only be maintained if casualty insurers can continue to play the important total role which they have traditionally fulfilled in managing traumatic injuries.

Trauma injuries of all types and causes—occupational and non-occupational, automobile and other accidents, constitute only between 7 and 8 percent of the total health care bill. The portion of this which could be attributed to catastrophe is obviously much less. It is suggested that the emphasis on total trauma care management, a role filled by the casualty insurer, will subside if a catastrophe plan in part displaces the role played by the casualty insurer. National health benefit administrators will not find it economically attractive to divert substantial management functions which would have little if any benefit impact on comparatively small percentage of their cases. On the other hand, trauma injuries constitute the overwhelming majority—if not the totality of casualty insurance business. Casualty insurance company management has specialized in the care of trauma from the scene of the accident to that point in time that the injured is returned to society in as near to its original condition as possible. It should be against public interest to displace this specialty.

VII. COORDINATION OF BENEFITS

Having made the case for the need to coordinate medical benefit systems, how does one go about practically coordinating these systems?

Medical benefits paid under casualty coverages fall broadly into two separate categories. On the other hand, such benefits are paid under no-fault type insurance systems, such as workmen's compensation, automobile no-fault, etc. These benefits are readily identifiable. On the other hand, substantial medical benefits are paid under the tort liability system to reimburse medical losses incurred as a result of someone else's negligence. These benefits, although not as clearly identified as in the case of no-fault benefits, nevertheless represent very real reimbursement for medical care losses.

As related to the tort liability systems, it is suggested that the catastrophic health insurer be given the right to subrogate against any available tort liability benefits sources. This will allow for sufficient flexibility to insure on the one hand, that the individual in need of medical care will receive the care at the time the need arises. However, through the subrogation mechanism, the ultimate cost of this medical care will be charged against the negligent party.

This is in fact what is taking place today under most state workmen's compensation laws. The framers of our workmen's compensation system felt that duplicating tort and workmen's compensation benefits was most undesirable. Accordingly, the structured workmen's compensation laws so as to allow that workmen's compensation benefits be paid immediately upon the occurrence of an accident but also provided for the recovery of these payments, through subrogation mechanisms, once the tort action had been decided. This allows for the best of all worlds. The injured employee is paid both his indemnity and medical benefits at the time of the injury, when he is in need of those benefits. The employer is not, however, charged with the cost of these benefits. The cost is ultimately charged against the negligent party.

The desirability and equity of the subrogation mechanism has been recognized by this Committee and Congress. It will be recalled that in 1967 this Committee amended the Title XIX by requiring that no state Medicaid program could be approved unless it contained a provision authorizing Medicaid to recover from any liable third-party, the cost of benefits paid on behalf of any Medicaid beneficiary. The July 1970 Medicaid Bulletin issue notes that in Maryland, \$305,138 had been recovered from insurance companies during a recent six week period.

Another example of the Congressional recognition of the desirability of the subrogation principle is contained in the armed forces dependents' medical aid program—CHAMPUS. We can assure you that the Defense Department assiduously pursues its subrogation rights under the law, thus substantially reducing the taxpayers' cost of the program.

The subrogation mechanism is not, however, needed to coordinate a national catastrophic illness insurance and no-fault insurance benefits. The most widespread no-fault insurance program in existence today is, of course, our workmen's compensation system. When this Committee structured Title XVIII in 1965, it recognized the need for coordinating Medicare and workmen's compensation benefits. The Committee incorporated in the Medicare law a provision barring the payment of Medicare benefits to the extent that workmen's compensation benefits are also payable for the same condition to the beneficiary. This provision has worked extremely well. Beneficiaries can be paid for the cost of their medical expenses, yet, the Medicare program has not been charged with any portion of the cost of the industrial injuries. Beneficiaries are not using any of their Medicare benefits. Thus protecting their coverage in case they may need them at a later date for some non-industrial illness. This precedent established by this Committee should be expanded to eliminate any possible duplication between health insurance and workmen's compensation benefits. In fact, many of the legislative proposals pending before this Committee do just that.

The very same approach is the logical one to adopt in coordinating catastrophic illness insurance benefits with other government mandated, first-party insurance programs. Foremost among these are no-fault auto insurance plans which more and more state legislatures are enacting today. There is no reason whatsoever to charge part of the cost of no-fault insurance losses to a catastrophic illness plan at the levels indicated by S. 1376, and there are many reasons, as cited above, why the cost of these benefits should be internalized within the automobile transportation system. Does it not make sense to first exhaust first-party, no-fault automobile benefits and then, if these benefits are not sufficient to cover the total loss, fill whatever gaps might remain by applying the catastrophic illness program?

Automobile no-fault insurance coverage is but one example of this new breed of insurance protection. Within the reasonable future, it is likely that a good many injuries associated with airline crashes might be handled on a no-fault basis and, it is possible that a National Commission presently studying malpractice insurance problems may recommend substantial involvement of first-party benefits in malpractice claims. All these no-fault benefit programs should bear the total cost of the losses which they generate. These programs should not in part, be subsidized by a governmental program and, in fact, the limited resources available for catastrophic insurance should be carefully nurtured so that the largest amount of benefits will be available for the most people, at the lowest cost.

VIII. CONCLUSION

In conclusion, we want to reemphasize our concern at the further fragmentation of our health care financing system. This can only lead to increased cost and increased specialization. We must stress that the financing of catastrophic illness cost must be incorporated in a total medical care financing program. Furthermore, this total program must also be coordinated with existing medical payment systems in order to avoid wasteful duplication.

AMERICAN INSURANCE ASSOCIATION,
Washington, D.C., February 8, 1972.

To: The Members of the Committee on Finance

GENTLEMEN: One of the most important issues to be considered in the development of a Catastrophic Illness Insurance program is the impact of such a program system now in effect throughout the country and the no-fault automobile insurance programs now being enacted in many states.

We believe that the Catastrophic Illness Insurance legislation should specifically provide as it now does that benefits under workmen's compensation be primary to those under a Catastrophic Illness Insurance program, and urge that the proposal be amended to make no-fault automobile insurance systems primary as well.

The enclosed statement submitted by our organization of more than 100 property and casualty insurers sets forth the reasons underlying our position. We urge you to give the statement your close attention.

We hope that, after reading the statement, you will be convinced that the goals of a Catastrophic Illness Insurance systems can be achieved at greatly reduced cost to the American tax payer by making benefits under such a system supplemental to those under workmen's compensation and no-fault automobile insurance programs.

Please feel free to call upon us if we can provide further information.

Sincerely,

T. LAWRENCE JONES, *President.*

Enclosure.

STATEMENT OF AMERICAN INSURANCE ASSOCIATION ON S. 1376, THE "CATASTROPHIC ILLNESS INSURANCE ACT," FEBRUARY 8, 1972

Mr. Chairman and Members of the Committee on Finance: The American Insurance Association, whose membership of more than 100 insurance companies writes all lines of property and casualty insurance throughout the United States, appreciates the opportunity to express its views on certain aspects and implications of S. 1376, the "Catastrophic Illness Insurance Act," which is currently pending before the Committee.

The membership of the American Insurance Association includes many of the major writers of group health insurance; automobile bodily injury, property damage and collision insurance; workmen's compensation; and individual accident and health insurance. In addition, at least one of our member companies has served as an administrative agency for the Medicare program. Accordingly, we believe our views come from balanced, first-hand knowledge and experience.

A substantial proportion of our membership also belongs to the Health Insurance Association of America, whose testimony the Committee will receive. We support the recommendations of the HIAA on the substantive aspects of the pending legislative proposal.

We are submitting this statement because we are concerned about the possible impact of a catastrophic illness insurance program on the no-fault automobile insurance that we are confident will become compulsory in an increasing number of states in the years to come. We note that S. 1376 as now written excludes the payment of benefits under the proposed legislation in cases in which similar benefits are payable under existing workmen's compensation plans. On page 5, lines 19-23 of S. 1376, such payments, which pursuant to Section 1862(b) of the Social Security Act (42 U.S.C., 1395y(b)), may not be made under Title XVIII, would likewise be precluded under this Act. We endorse this exclusion and urge the Committee to exclude as well no-fault automobile insurance benefits for the reasons set out below.

INTRODUCTION

We believe that any catastrophic illness insurance system created by the Congress should seek to take advantage of existing insurance systems to the extent that the goals of those systems are compatible with the goals of a catastrophic illness program, and to the extent that they can assure cost savings while providing the same uniformity and universality of protection. This belief, as well as the other viewpoints offered in this statement, would apply to any type of national health insurance program which the Congress might consider. Our remarks are, of course, presented in the context of a specific legislative proposal, but the principle of making automobile no-fault insurance primary is, in our view, essential in any case.

The preservation of private systems for the compensation of auto accident-related injuries will not only result in a lower cost to the consumer and in considerable savings to the Federal Government, but will serve several major public policy objectives.

It is hardly debatable that personal and property injuries suffered in automobile accidents may be truly "catastrophic" in their impact upon a victim. It has become abundantly clear that the traditional third party system, grounded as it is in the tort liability concept, and thus subject to all the vagaries and uncertainties of potential and actual litigation, is simply unworkable as a means of timely and sufficient compensation. Many persons get nothing, or, at best, only a portion of the compensation to which they are entitled and then only after unconscionable delays.

Thus, the goals of a catastrophic illness insurance program and of the no-fault automobile insurance system are the same: (1) the provision of adequate economic loss benefits for all at minimum cost; and (2) the restructuring of the framework under which these benefits are delivered in order to reduce frictional costs, eliminate waste and duplication, redirect resources to reduce the frequency and severity of losses, and encourage rehabilitation.

Making benefits under no-fault automobile insurance excess of (that is, payable after) benefits under a catastrophic illness program is not essential to the achievement of the goals common to both systems. Indeed, as we shall demonstrate below, the objectives of both systems will be enhanced if benefits under no-fault automobile insurance are made primary to benefits under a catastrophic illness system.

NO-FAULT AUTO INSURANCE SHOULD BE PRIMARY

1. The Costs of Motoring Should Be Internalized to the Activity of Motoring.

We think it is important for a number of reasons to internalize to motoring the cost of that activity, so that automobile accident costs will be accurately reflected in auto insurance prices.

For consumers generally, automobile accident costs should be internalized to the activity of motoring in a visible way, one that shows on the price tag. The accident cost of motoring can best be internalized to the activity of motoring through the no-fault insurance mechanism, one that makes the cost visible before, rather than after, the consumer decides whether, when and how much to engage in the activity of motoring.

More than one-half of the American population does not drive automobiles. The 110 million non-motoring American people should not be forced to subsidize a portion of the losses generated by the motoring segment of the American public through higher taxes for a catastrophic illness program.

From the point of view of the accident victim, it is only fair that his losses be paid for by the motoring populace through their common contributions to the no-fault auto insurance pool, rather than by society at large through its contribution to a catastrophic illness insurance system.

It should also be noted that the variations in auto insurance prices which would result from making catastrophic illness insurance benefits primary would serve to frustrate the potential of no-fault automobile insurance to reverse the existing pattern of auto insurance costs, in which those least able to afford it frequently pay the highest premiums. If catastrophic illness benefits are primary, the affluent driver secure in a job with good fringe benefits will continue to pay less for his auto insurance than the center city dweller whose employment typically has less tenure and fewer fringe benefits.

2. Motoring Accident Losses Merit Separate Treatment

Four out of every five American families own a car. More than 105 million licensed drivers use more than 100 million cars on our streets and highways. There is a 99 percent chance that in 20 years of driving, every one of these drivers will have at least one accident. Each year, motoring activity results in 56,000 deaths and 4.6 million injuries (of which half are serious and 4 percent result in permanent disability.) The economic loss to the nation from the carnage on our highways amounts to \$16.5 billion per year.

Moreover, 7.7 percent of all disabilities are attributable to automobile accidents; 21.5 percent of the overall number of days of disabilities from accidents are attributable to auto crashes; and 49 percent of all accidental deaths in America each year are attributable to auto accidents.

Although auto accident-related medical expenses constitute less than 5 percent of the total annual medical expense outlay in the United States, the types of injuries and disabilities are significantly different from nonauto related injuries to justify their treatment and compensation under a system directed exclusively to them.

The elimination of the adversary process in the compensation of auto accident victims will make it unnecessary for accident victims to postpone treatment or to hide the nature and extent of their injuries. Thus, insurers will be able to bring to bear on automobile accident injuries the expertise they have developed through the rehabilitation of trauma cases under the workmen's compensation system.

The effect of this expertise would be greatly diluted if auto accident injuries were compensated by a catastrophic illness system whose benefits are primary to

those under no-fault automobile insurance. Conversely, if no-fault automobile insurance medical benefits were primary, auto insurers could make significant contributions to the medical and economic recovery of automobile accident victims.

3. *No-Fault Auto Insurance Eliminates the Need for Collateral Sources*

Because the current automobile liability insurance policy is designed not to compensate the policyholder for his accident losses, but to protect him from the economic consequences of judgments against him, prudent drivers today must rely on other forms of insurance to pay their hospital and medical expenses resulting from automobile accidents in which they are either "at fault" or precluded from recovering from other parties by their "contributory negligence."

The elimination of questions of legal fault from auto accident reparations and the adoption of a compulsory first-party auto insurance system will reverse the current situation. Each driver will be able to look to his own insurer for full and immediate payment of *all* hospital and medical expenses and other economic losses incurred by those injured in his automobile.¹

It has been estimated that 45 percent of the average traffic accident victim's total recovery today for personal injury and property damage is derived from sources completely outside the fault insurance system (e.g., accident and health insurance and income continuation plans) and from no-fault insurances engrafted upon the fault insurance system (e.g., medical payments and collision insurance.)

No-fault auto insurance will eliminate the waste and inefficiency inherent in a system that makes the majority of the accident victim's compensation contingent on his being found free of legal fault for the accident.

At the same time, it will unify in a single policy the benefits now payable, if at all, from a wide variety of frequently duplicative sources.

4. *Private No-Fault Auto Insurance Would Be as Efficient as Catastrophic Illness Insurance*

No-fault auto insurance encompasses not only unlimited hospital, medical and rehabilitation benefits, but also wage loss benefits of up to \$1,000 a month, replacement household service benefits for injured housewives, and compensation for damage to vehicular and non-vehicular property. With this broad range of claim services to perform, the insurer's expenses naturally are higher than in lines of insurance offering less comprehensive benefits.

Shifting the administrative costs of processing automobile bodily injury claims to a catastrophic illness system would not greatly reduce the administrative burden of the no-fault automobile insurer, since any accident causing significant injury would undoubtedly be accompanied by a considerable degree of property damage. Thus, the automobile insurer would be involved in any event, and the additional cost of processing the injury portion of the claim would be negligible. Also, a shift of the administrative cost would limit the capacity of the private no-fault auto insurance system, while imposing on the catastrophic illness plan the cost of processing some 4.6 million auto bodily injury claims, thus adding unnecessary costs to such a plan.

We firmly believe that coordination of benefits among alternative sources is essential in catastrophic illness legislation. The most efficient coordination of benefits in the auto accident compensation area would be one which makes the more comprehensive of two mandatory systems, that is, the no-fault system, primary to the less comprehensive system, that is, catastrophic illness insurance.

5. *Primary Catastrophic Illness Insurance Would Be Inequitable to Motorists*

If a no-fault auto insurer were forced to discover and confirm the extent of collateral benefits available to injured accident victims, an extensive administrative mechanism would have to be established which might present a threat to the victim's privacy and result in serious delays in the payment of benefits.

If, as we believe they should be, first-party, no-fault auto insurance benefit levels are high enough to cover virtually all economic losses for virtually all auto accident victims, auto insurance coverage will be the most complete and comprehensive coverage available.

¹ For a description of how such a system would operate see the *Report of the Special Committee to Study and Evaluate the Keeton-O'Connell Basic Protection Plan and Automobile Accident Reparations*, American Insurance Association, New York 1968, pp. 5-7; and *Motor Vehicle Crash Losses and Their Compensation in the United States*, U.S. Dept. of Transportation, March, 1971, pp. 133-37.

If auto insurance benefits are secondary in a catastrophic illness plan, the benefits may be exhausted by auto-related injuries and disabilities, leaving the insured unprotected from the financial consequences of other, non-auto related disability.

WORKMEN'S COMPENSATION BENEFITS SHOULD REMAIN PRIMARY

As noted earlier, the catastrophic illness proposal now before the Committee maintains the integrity of the existing workmen's compensation plans by making them primary. The Association applauds this provision and urges that it be retained for the following reasons:

1. *The Workmen's Compensation System Serves American Workers and Employers Well.*

For most American workers the greatest risk is the very real possibility of having to leave their employment because of an occupational disability. Even relatively nonserious injuries or illnesses may result in medical care expense while the more serious disabilities may cause a temporary or permanent loss of earning ability along with the burden of catastrophic medical expenses. Likewise, liability for such losses is an equally real threat to employers.

The present system of Workmen's Compensation, operating within the framework of regulation at the state level, has proven to be a highly efficient method of protecting employees and employers against the hazards of work-connected injuries.

2. *The Importance of Medical Care to Workmen's Compensation.*

One of the most compelling reasons against making workmen's compensation payable after catastrophic illness insurance is the fact that medical care is an integral part of the workmen's compensation system. The adequacy and quality of medical care and the prompt initiation of a rehabilitation program where necessary are of great importance to the injured man and the proper operation of the system.

3. *Workmen's Compensation Provides Comprehensive Protection.*

It may be noted that under neither the Medicare program nor the Medicaid program do the extent of medical care benefits approach those provided under the workmen's compensation system. Medical protection under workmen's compensation laws provides the most comprehensive system of statutory health care in this country. Full medical, hospital and related services, unlimited in time or amount, are an essential part of the widespread protection that workmen's compensation laws in most states provide against income loss from and treatment for work injuries. Severe injuries involving large expenditures for medical care, while fortunately infrequent, are by no means unknown. Current medical payments under workmen's compensation laws exceed \$1,000,000,000 annually.

4. *Catastrophic Illness Insurance Could Be More Costly Than Workmen's Compensation.*

Another factor which should weigh significantly in deciding whether catastrophic illness insurance should be primary to workmen's compensation is the fact that Medicare and Medicaid have far exceeded cost estimates made prior to their enactment. There is every reason to believe that treatment of work related injuries under a primary catastrophic illness insurance program would also be extremely costly. For the Federal Government to assume this large burden is unsound both economically and practically, in light of the fact an effective and comprehensive medical benefit program for work injuries already exists.

CONCLUSION

For the reasons above, we strongly urge the Committee to retain in its catastrophic illness legislation language making workmen's compensation benefits primary to catastrophic illness insurance benefits and broaden the concept to provide that mandatory first-party automobile accident insurance be the primary source of indemnity for auto accident injuries.

We would suggest the addition of the following language to S. 1376 in order to accomplish this intent: Amend the bill on page 5, lines 19 through 23 to read:

(b) (1) Notwithstanding the previous provisions of this Section, no payment may be made with respect to expenses or services payable under mandatory,

first party no-fault automobile insurance programs, or if pursuant to Section 1862(a), (b), or (d) payment may not be made for such expenses under Title XVIII.

We would be happy to meet with members of the Committee or the Committee Staff to discuss in further detail the recommendations contained in this statement.

Respectful submitted,

AMERICAN INSURANCE ASSOCIATION,
T. LAWRENCE JONES, *President*.

The CHAIRMAN. The next witness will be Clark C. Havighurst, professor of law, Duke University School of Law.

**STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW,
DUKE UNIVERSITY SCHOOL OF LAW**

Mr. HAVIGHURST. Thank you, Mr. Chairman.

My name is Clark C. Havighurst, and I am a professor of law at Duke University. For the past 2½ years I have been director of the Committee on Legal Issues in Health Care, which is organized under a contract with the National Center for Health Services Research and Development, U.S. Department of Health, Education, and Welfare. I am appearing here in my individual capacity, however, and do not purport to speak for the members of the Committee on Legal Issues in Health Care.

My interest in the health care industry grows out of my academic interests in the fields of industrial organization, antitrust law, and public regulation of business. I have recently spelled out my views on many of the matters now being considered by your committee in a lengthy article entitled "Health Maintenance Organizations and the Market for Health Services," which is published as part of a symposium on health care which I edited for the journal "Law and Contemporary Problems." That article strongly endorses most of the provisions of H.R. 1 relating to health maintenance organizations, and my testimony today is confined to discussing those provisions.

This bill is likely to be the first act of Congress to endorse the HMO concept and it is therefore an important step in pointing the direction in which the health care system is to move. It is my view that if HMO's are permitted to develop without unnecessary legislative or regulatory restrictions, they will stimulate limited but nevertheless effective competition in health care delivery and should substantially improve the performance of the entire health care industry. It is wrong to say, as many have, that the administration's program is unlikely to bring about needed basic changes in the health care delivery system. In fact, the policy of encouraging the development of HMO's has the potential for revolutionizing the entire industry.

My optimistic expectations for HMO's rest, first of all, on their ability to impose, almost for the first time, a needed cost constraint on physicians in caring for their patients. By discouraging overutilization and realizing other efficiencies, HMO's will be able to quote a lower price than do health insurers for the same benefits or to give more coverage for the same price. Such competition would introduce unprecedented but essential pressure to control costs in the insured fee-for-service sector, and health insurers and professional groups would be driven to institute at least a mild form of peer or other review cal-

culated to reach the most substantial abuses and thereby lower insurance premiums. Indeed, the appearance of medical care foundations, which are being organized by medical societies in response to the potential appearance of HMO's, is the most dramatic step to date in the direction of effective controls on utilization and charges in the fee-for-service sector. Much of the credit for this initiative by the medical societies should go to the administration's HMO proposals.

Just as the presence of HMO's in the market will induce utilization and cost controls by fee-for-service providers, the service advantages and other strengths of competing fee-for-service medicine will help to prevent HMO's from rendering excessively impersonal or unresponsive service and from cutting back on essential quality. Thus, the competition between the two segments of the industry, by increasing the need to appeal to consumers, improving the flow of information to the public, and augmenting opportunities for choice on the basis of price, quality, and convenience, will have healthy results from the standpoint of the public. Major gains are possible in reducing the cost of health care, in improving the overall quality of care, and in increasing consumer satisfaction with the conditions under which care is delivered.

The benefits that I foresee from introducing HMO's will not be fully realized if care is not taken in legislation to keep market entry by a new HMO from being any more difficult than it has to be. Indeed, the widespread agreement on the need for subsidies and for promotional assistance to HMO development indicates a prevailing belief that entry must be made as easy as possible. Moreover, the object should be to permit entry by as many HMO's as possible and to encourage the development of different models of HMO in order that consumer choice will be maximized and new ideas and organizational forms can be tried. The thrust of my remarks today is toward assuring that H.R. 1 will not pose any unnecessary entry barriers to HMO development and will in fact embody a policy of encouraging HMO's of all kinds to serve medicare patients and to compete for the custom of other consumers as well.

My first concern is that H.R. 1 not overspecify what an HMO must be. The present definition of health maintenance organization in H.R. 1 is quite general in most of its aspects and would probably permit the formation of almost any responsible plan embodying prepayment to the provider on a capitation basis and acceptance by the provider of contractual responsibility for the patient's comprehensive health needs. If properly administered, it should exclude no plan that is well conceived and fair to consumers.

However, in 1970 this committee indicated a desire to impose additional limits on the HMO concept embodied in H.R. 17550. I hope that this time you will not give in to the very great temptation to write an idealized HMO model into law. Any legislative attempt at particularizing the model bars some potential entrants, by increasing the needed investment, eliminating certain classes of aspirants, or otherwise. It is widely recognized also that the specification of "inputs" in a process can be a costly regulatory approach, increasing production costs without necessarily assuring or commensurately improving the quality of output.

H.R. 1 should be regarded as an enabling act permitting medicare beneficiaries to elect HMO-type care and not as the vehicle for imposing detailed regulation on HMO's. Congress will have ample opportunity to consider regulatory measures applicable to HMO's and perhaps to other health care providers as well. Indeed, bills to deal with possible quality problems associated with HMO's are currently being drafted in a number of places, and one of these will almost certainly be acted on by the end of this session.

I might add here that I hope Senator Bennett's PSRO proposals will not give the fee-for-service doctors or the medical societies any regulatory authority over HMO's—except the medical care foundations, of course.

Senator BENNETT. Well, at this point if the amendment is adopted the fee-for-service doctors will share with the doctors from HMO the responsibility of checking the performance of fee-for-service doctors and HMO's. We think we have got to cross that line. We don't think we can allow HMO's to grow up any more than we can allow hospital review groups to grow up and say, "Our utilization review is perfect. Therefore, we should be free from any further utilization review."

That is really the fox in the henhouse.

Mr. HAVIGHURST. Well, Senator, you are aware, of course, of the history of the difficulties that HMO's have had—

Senator BENNETT. That's right.

Mr. HAVIGHURST (continuing). In dealing with the fee-for-service sector and of the activities of the fee-for-service sector in repressing HMO development.

Senator BENNETT. I am aware of mutual jealousy that exists between the two groups and each side feels for some reason the other type of practice should either not exist or if it exists should not be allowed to have any relationship; they should be kept apart and be independent. But as we move toward national health programs, and I may not be in the Senate when they come, but some form of national health program will come in this century; it seems to me we must have an overall review mechanism which reviews all aspects, all types of health services and I think the PSRO concept is so built that we are not going to let outside physicians review HMO's unless representatives of the HMO involved are part of the review mechanism any more than we should allow the HMO people to have a free hand in reviewing the private practice.

Teh hospitals say the same thing. They say—you heard the witness today—in effect: "We have utilization review procedures; therefore you don't need to review us." Well, I think the doctors who are part of hospital staffs, the doctors who are part of HMO's and the doctors who are in private practice should all be brought into the review mechanism so that we have representatives of every phase of the medical industry reviewing all aspects or all types of medical services.

Mr. HAVIGHURST. Your remarks, Senator, fly somewhat in the face of my conception—which I have tried to lay out here—of the two sectors competing with each other in a substantial way. I would simply point out that cooperative types of regulation may result in unfortunate collusion if they avoid the danger of suppression of the HMO sector by the fee-for-service doctors.

Senator BENNETT. They are going to compete with each other financially and the review mechanism has nothing to do with the cost of service. It has to do with the quality and effectiveness, and the site of service; otherwise, if you take a fragmented approach then you can say every sector, every factor in the providing of health service, wants to do its own reviewing without anybody else looking at it. Some nurses want to review nurses; and podiatrists want to review podiatrists; and chiropractors want to review chiropractors.

Mr. HAVIGHURST. Senator, the interesting thing about the medical foundation concept is that for the first time the fee-for-service sector has really gotten interested in policing itself to eliminate real abuses. Up until now they wanted to police themselves only so that no one else would do it.

Senator BENNETT. That's right.

Mr. HAVIGHURST. Now, because HMO's have appeared, there is a real incentive to control cost and utilization, and that, you see, to me is a desirable development; and, to the extent that that is what is going on, I find it very, very attractive. Whether PSRO is simply an extension of that concept is not clear to me at this point.

Senator BENNETT. The foundation—the real proliferation of the foundation idea followed PSRO; it did not precede it; and it is my personal concept that we have got to have every type of medical practitioner at the physician level, not physiotherapist or the nurse, have an opportunity to participate in the review mechanism; and, in order to make it effective the process of review must go into every type of medical practice, otherwise we are building up a little group of walls around existing programs and each of them is saying, as you heard the hospital people say this morning, "We don't want them to review us. We have our own review mechanism and it is satisfactory."

Mr. HAVIGHURST. If you can conceive of a somewhat more competitive market system, though, the notion that there is a certain balkanization is not so troublesome, because each of these groups—the fee-for-service sector, on the one hand, and a variety of HMO's on the other—is competing against the others to achieve the right combination of cost, quality, amenities, and so on.

Senator BENNETT. I realize you are testifying today for the creation of more HMO's and can you conceive possibly that there are some doctors who would get together and conceive of an HMO that probably should have some outside review?

Mr. HAVIGHURST. Yes, I can, Senator.

Senator BENNETT. That is all I am interested in——

Mr. HAVIGHURST. Precisely.

Senator BENNETT (continuing). In seeing that it is possible.

Mr. HAVIGHURST. I simply would resist the idea of assigning that review job to fee-for-service doctors. I have not studied the mechanism that you have proposed sufficiently to say whether that is a substantial risk, and I would just ask you and the committee recognize it as a danger to be avoided.

Senator BENNETT. That is right; the concept in the Bennett proposal is that in an area where there is an HMO, we are more or less going to insist that the HMO doctors be part of the review mechanism just as fee-for-service doctors and hospital staffs' members. We have got to get them all in or the thing will not operate.

Mr. HAVIGHURST. I will now return to my prepared remarks.

In the connection that I was pursuing previously, I want now to argue specifically that H.R. 1 should prescribe no minimum size for HMO's.

In 1970, this committee introduced a minimum size requirement for HMO's into its version of H.R. 17550. This action reflected a judgment about the minimum efficient size of HMO's, but its effect would have been to rule out all possibility of HMO's run by a small group of doctors—roughly less than 10—perhaps in a rural community or in conjunction with a fee-for-service practice.

Small HMO's, rendering mostly primary care and purchasing specialist services and hospital care in the fee-for-service sector, could serve a useful function in the health care system, even if they were somewhat less efficient than their larger competitors. Their physicians might provide more personalized care and would act as particularly sophisticated purchasers in obtaining fee-for-service care for their enrollees, shopping on the basis of price and quality and exercising a beneficial influence on utilization. Just as specialty shops continue to compete with more efficient department and discount stores, smaller HMO's may find a place in the health care industry, perhaps charging a higher price but providing something closer to the personalized care that fee-for-service medicine can provide.

Most important of all, a minimum size requirement would probably guarantee that no more than one HMO could establish itself in many communities, even some of substantial size. These monopolistic HMO's might have no substantial incentive to maximize the attractiveness of HMO-type care, particularly if they were dominated directly or indirectly by fee-for-service doctors through the medical care foundation device or through sponsorship by a university medical center or a community hospital. Maximum development of the HMO concept requires that entry not be artificially obstructed by minimum size or other requirements.

My next point is that H.R. 1's present controls on HMO profits are completely adequate and should not be strengthened.

This committee's version of H.R. 17550 sought to restrict the profitability of HMO's and there are some who would prohibit for-profit HMO's altogether. H.R. 1 now restricts the HMO's profits on medicare beneficiaries to the rate earned in serving self-supporting subscribers. I submit that this provision is the best means of handling any question concerning the profits earned by HMO's.

Without some profit incentive, HMO's will grow more slowly, and competitive situations will be less likely to develop. Even nonprofit HMO's grow in large part because their organizers seek power, prestige, and perquisites that come with organizational success, and to this extent nonprofit and for-profit enterprises are hardly distinguishable. Moreover, doctors and administrators may gain personally from running an ostensibly nonprofit HMO, and proscription of for-profit plans succeeds only in barring nonmedical persons or corporations and their capital from entrepreneurial roles in health care, depriving the industry of precisely those resources and talents needed to reorganize it.

The loss of potential entrants, particularly the most aggressive kind, reduces the pressure on existing providers to satisfy consumer prefer-

ences on cost, quality, and the conditions under which care is given. Again, for-profit HMO's would be more likely to develop the full potential of HMO-type care than might most nonprofit providers, which would usually be dominated by, or in some respect beholden to, fee-for-service providers.

I have argued the case for for-profit HMOs' at length in the "Law and Contemporary Problems" article.

My final point is that the provisions of H.R. 1 giving Federal effect to State health planning requirements affecting HMO's should be eliminated. Section 221 of H.R. 1 as passed by the House of Representatives appears to strengthen State authorities' power effectively to control all major new public and private investments in health facilities, including HMO's, and to prevent all new construction for which they are not satisfied that a "need," as they define it, exists. Experience in other regulated industries tells us that need in such circumstances is always defined with an eye to possible adverse effects on other providers of the service, indicating that legislation of this kind invariably protects existing providers from competition, which explains why it is regularly sponsored by them.

In health care, the problem is exacerbated by the unfortunate fact that the State health planning agencies have already reached the status, which most regulatory agencies may be fated to attain, of being the captive of the establishment they are expected to regulate. Thus, State health planning laws have a protectionist, monopolistic tendency that must be minimized if a responsive, pluralistic system is desired.

In my prepared statement I elaborated my doubts about the wisdom of State hospital franchising laws that extend to private sector investments. In my view they are shortsighted and, while possibly justified by expediency under present conditions, will in the long run have detrimental effects. Whatever kind of national health insurance scheme is eventually adopted, it will be less attractive if the legal background is such that health care is provided by a series of local monopolies protected from competition by certificate-of-need legislation.

Although I have these broader doubts, in this statement I propose only that section 221 of H.R. 1 be returned to the form in which it was originally proposed by the administration so as not to extend to HMO investments specifically. In this form it would still reach the construction of hospital facilities by HMO's but would give no Federal sanction to State restrictions on the construction of outpatient facilities.

Nothing could be more pernicious than to give to State regulatory agencies dominated by, or responsive to the interests of, fee-for-service providers the power to veto the creation of new HMO's.

In summary, I would simply solicit the committee's recognition of the overriding importance of preserving opportunities for HMO entry. I hope that you will find this is an appropriate occasion to declare either in legislation or in legislative history that the law shall be administered with a view to achieving the objective of a pluralistic, nonmonopolistic system of health care delivery.

The CHAIRMAN. Thank you very much, sir.

Any further questions?

Thank you very much for your statement.

(The prepared statement of Mr. Havighurst follows:)

PREPARED STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW,
DUKE UNIVERSITY,

My name is Clark C. Havighurst, and I am a professor of law at Duke University. For the past 2½ years I have been Director of the Committee on Legal Issues in Health Care, which is organized under a contract with the National Center for Health Services Research and Development, U.S. Department of Health, Education, and Welfare. I am appearing here in my individual capacity, however, and do not purport to speak for the members of the Committee on Legal Issues in Health Care.

My interest in the health care industry grows out of my academic interests in the fields of industrial organization, antitrust law, and public regulation of business. I have recently spelled out my views on many of the matters now being considered by your Committee in a lengthy article entitled "Health Maintenance Organizations and the Market for Health Services," which is published as part of a symposium on Health Care which I edited for the journal *Law and Contemporary Problems*. That article strongly endorses most of the provisions of H.R. 1 relating to health maintenance organizations (HMOs), and my testimony today is confined to discussing those provisions.

This bill is likely to be the first act of Congress to endorse the HMO concept, and it is therefore an important step in pointing the direction in which the health care system is to move. It is my view that, if HMOs are permitted to develop without unnecessary legislative or regulatory restrictions, they will stimulate limited but nevertheless effective competition in health care delivery and should substantially improve the performance of the entire health care industry. It is wrong to say, as many have, that the administration's program is unlikely to bring about needed basic changes in the health care delivery system. In fact, the policy of encouraging the development of HMOs has the potential for revolutionizing the entire industry.

My optimistic expectations for HMOs rest, first of all, on HMOs' ability to impose, almost for the first time, a needed cost constraint on physicians in caring for their patients. By discouraging overutilization and realizing other efficiencies, HMOs will be able to quote a lower price than do health insurers for the same benefits or to give more coverage for the same price. Such competition would introduce unprecedented but essential pressure to control costs in the insured-fee-for-service sector, and health insurers and professional groups would be driven to institute at least a mild form of peer or other review calculated to reach the most substantial abuses and thereby lower insurance premiums. Indeed, the appearance of medical care foundations, which are being organized by medical societies in response to the potential appearance of HMOs, is the most dramatic step to date in the direction of *effective* controls on utilization and charges in the fee-for-service sector. Much of the credit for this initiative by the medical societies should go to the administration's HMO proposals.

Just as the presence of HMOs in the market will induce utilization and cost controls by fee-for-service providers, the service advantages and other strengths of competing fee-for-service medicine will help to prevent HMOs from rendering excessively impersonal or unresponsive service and from cutting back on essential quality. Thus, the competition between the two segments of the industry, by increasing the need to appeal to consumers, improving the flow of information to the public, and augmenting opportunities for choice on the basis of price, quality, and convenience, will have healthy results from the standpoint of the public. Major gains are possible in reducing the cost of health care, in improving the over-all quality of care, and in increasing consumer satisfaction with the conditions under which care is delivered.

For the foregoing reasons, the extent of HMO's actual penetration of the market in terms of subscribers enrolled will not directly measure HMO's overall value to consumers, and indeed consumers may continue in large numbers to prefer fee-for-service care even at a higher price. Nevertheless, an available substitute, even if it is perceived to be somewhat inferior, can impose an effective check on the exercise of market power, resulting in lower prices and greater efficiency than would otherwise prevail. Thus, even if HMO-type care should appear inferior in some respect to fee-for-service medicine (and there is no evidence to date of any such inferiority), it still has a vitally important market function to perform.

The benefits that I picture from introducing HMOs will not be fully realized if care is not taken in legislation to keep market entry by a new HMO from

being any more difficult than it has to be. Indeed, the widespread agreement on the need for subsidies and for promotional assistance to HMO development indicates a prevailing belief that entry must be made as easy as possible. Moreover, the object should be to permit entry by as many HMOs as possible and to encourage the development of different models of HMO in order that consumer choice will be maximized and new ideas and organizational forms can be tried. The thrust of my remarks today is toward assuring that H.R. 1 will not pose any unnecessary entry barriers to HMO development and will in fact embody a policy of encouraging HMOs of all kinds to serve medicare patients and to compete for the custom of other consumers as well.

The following paragraphs deal with several technical aspects of H.R. 1 as it is now constituted and as it might be reconstituted by this Committee. In each case the emphasis is on maximizing entry possibilities as a means of maximizing the chances of realizing the expectations expressed above.

H.R. 1 should not overspecify what an HMO must be.

The definition of "health maintenance organization" in H.R. 1 is quite general in most of its aspects and would probably permit the formation of almost any responsible plan embodying prepayment to the provider on a capitation basis and acceptance by the provider of contractual responsibility for the patient's comprehensive health needs. However, the definition would permit, although it would not require, a degree of regulatory prescription by the Secretary of HEW that might effectively narrow entry opportunities. Thus, financial responsibility and quality assurance requirements, contemplated in H.R. 1, could be made excessively burdensome, increasing HMO costs and entry problems without commensurate benefits to the consumers served. Although my preference might be for a bill conferring even less prescriptive powers on the government, the present bill is acceptable since its requirements are largely minimal and, if properly administered, it should exclude no plan that is well conceived and fair to consumers.

In 1970 this Committee indicated a desire to impose additional limits on the HMO concept embodied in H.R. 17550. I hope that this time you will not give in to the very great temptation to write an idealized HMO model into law. Any legislative attempt at specifying the model bars some potential entrants, by increasing the needed investment, eliminating certain classes of aspirants (such as nonphysicians capitalists), or otherwise. It is widely recognized also that the specification of "inputs" in a process can be a costly regulatory approach, increasing production costs without necessarily assuring or commensurately improving the quality of output. H.R. 1 should be regarded as an enabling act permitting Medicare beneficiaries to elect HMO-type care and not as the vehicle for imposing detailed regulation on HMOs. Congress will have ample opportunity to consider regulatory measures applicable to HMOs and perhaps to other health care providers as well. Indeed, bills to deal with possible quality problems associated with HMOs are currently being drafted in a number of places, and something should be acted on by the end of this session.

H.R. 1 should prescribe no minimum size for HMOs.

In 1970 this Committee introduced a minimum size requirement for HMOs into its version of H.R. 17550. This action reflected a judgment about the minimum efficient size of HMOs (something the market is better equipped to determine than the legislature), but its effect would have been to rule out all possibility of HMOs run by a small group of doctors (less than ten), perhaps in a rural community or in conjunction with a fee-for-service practice. Small HMOs, rendering mostly primary care and purchasing specialist services and hospital care in the fee-for-service sector, could serve a useful function in the health care system, even if they were somewhat less efficient than their larger competitors. Their physicians might provide more personalized care and would act as particularly sophisticated purchasers in obtaining fee-for-service care for their enrollees, shopping on the basis of price and quality and exercising a beneficial influence on utilization. Just as specialty shops continue to compete with more efficient department and discount stores, small HMOs may find a place in the health care industry, perhaps charging a higher price but providing something closer to the personalized care that fee-for-service medicine can provide. Smaller HMOs also have a potentially useful function in currently underserved rural areas, where the population base might not provide enough enrollees for optimally efficient operation.

Most important of all, a minimum size requirement would probably guarantee that no more than one HMO could establish itself in many communities, even

some of substantial size. These monopolistic HMOs might have no substantial incentive to maximize the attractiveness of HMO-type care, particularly if they were dominated directly or indirectly by fee-for-service doctors through the medical care foundation device or through sponsorship by a university medical center or a community hospital. Maximum development of the HMO concept requires that entry not be artificially obstructed by minimum size or other requirements.

H.R. 1's present controls on HMO profits are adequate.

This Committee's version of H.R. 17550 sought to restrict the profitability of HMOs, and there are some who would prohibit "for-profit" HMOs altogether. H.R. 1 now restricts the HMO's profits on Medicare beneficiaries to the rate earned in serving self-supporting subscribers. It is submitted that this provision is the best means of handling the question of profits earned by HMOs.

Without a profit incentive HMOs will grow more slowly, and competitive situations will be less likely to develop. Even nonprofit HMOs grow in large part because their organizers seek power, prestige, and perquisites that come with organizational success, and to this extent nonprofit and for-profit enterprises are hardly distinguishable. Moreover, doctors and administrators may gain personally from running an ostensibly nonprofit HMO, and proscription of for-profit plans succeeds only in barring nonmedical persons or corporations and their capital from entrepreneurial roles in health care, depriving the industry of precisely those resources and talents needed to reorganize it. The loss of potential entrants, particularly the most aggressive kind, reduces the pressure on existing providers to satisfy consumer preferences on cost, quality, and the conditions under which care is given. Again, for-profit HMOs would be more likely to develop the full potential of HMO-type care than might most nonprofit providers, which would usually be dominated by, or in some respect beholden to, fee-for-service providers.

I have argued the case for for-profit HMOs at length in the *Law and Contemporary Problems* article.

The provisions of H.R. 1 giving federal effect to state health planning requirements affecting HMO should be eliminated.

Section 221 of H.R. 1, as passed by the House of Representatives, appears to strengthen state authorities' power effectively to control all major new public and private investments in health facilities, including HMO's, and to prevent all new construction for which they are not satisfied that a "need," as they define it, exists. Experience in other regulated industries tells us that "need" in such circumstances is always defined with an eye to possible adverse effects on other providers of the service, indicating that legislation of this kind invariably protects existing providers from competition and explaining why it is regularly sponsored by them. In health care, the problem is exacerbated by the unfortunate fact that the state health planning agencies have already reached the status, which most regulatory agencies may be fated to attain, of being the captive of the establishment they are expected to regulate. Thus state health planning laws have a protectionist, monopolistic tendency that must be minimized if a responsive, pluralistic system is desired.

Health planning has legitimate functions, of course, but limitation of competition is not clearly one of them and should be tolerated only if no other solution to the perceived problem is viable. Planning is clearly needed for the purpose of supervising and coordinating the health investments of the public and eleemosynary sectors to prevent redundant, extravagant, or even corrupt expenditures. Moreover, because of the extent of existing monopoly and the working of the third-party payment system in health care, excess capacity tends to be translated into higher costs and passed on directly to the public in the form of higher insurance charges or taxes. Finally, an excess of hospital beds in a community tends to invite overutilization of the hospital as administrators seek to keep their revenues up. The issue is whether these problems can be confronted only by limiting the possibility of new entry into health care delivery by extending planning to include private-sector investments. I believe that they can be, but this is not the place to deal with this question.

Another possible argument for "certificate-of-need" legislation is that competition is unfair and should be suppressed because it endangers public investments. As things now stand, community hospitals are indeed excessively vulnerable to competition from new entrants, in part because their rate structures do not reflect the costs of their various services but more fundamentally because they bear a considerable financial burden in serving the poor, much of which

must be covered by monopolistic charges to paying patients. Health insurance helps to spread these latter charges and prevents the monopolistic-charity model from being a totally irrational and inequitable way for society to absorb the cost of caring for the poor, but reliance on this model requires protective legislation and forfeits the benefits obtainable from preserving the possibility of new entry.

Provision of medical care for the poor is not fundamentally incompatible with a more competitive health care marketplace. Thus, the administration's proposals would pursue the more attractive route of providing the poor with adequate insurance coverage rather than subsidizing the providers of care by direct public grants or through award of monopolistic privileges. Of course, measures to improve disadvantaged citizens' ability to pay for care may reflect compassion for hard-pressed providers more than concern for the deprived poor themselves, but at least that compassion should not be carried to the extent of relieving providers of both the need to treat some nonpaying patients *and* the threat of competition. There is a real danger that the process of legislating protectionism will be completed at just about the time that the chief justification for it—the need to provide excess profits from which to subsidize free care for the indigent—is largely removed. Whatever kind of national health insurance scheme is eventually adopted, it will be less attractive if the legal background is such that health care is provided by a series of local monopolies protected from competition by certificate-of-need legislation.

I propose that section 221 of H.R. 1 be returned to the form in which it was originally proposed, so as not to extend to HMO investments specifically. In this form it would still reach the construction of hospital facilities by HMOs but would give no federal sanction to state restrictions on the construction of outpatient facilities. As indicated above, I also have grave doubts about the wisdom of section 221 as it applies to the construction of hospital facilities, but it is even more important that this provision not be permitted to restrict HMO development specifically. Nothing could be more pernicious than to give to state regulatory agencies dominated by, or responsive to the interests of, fee-for-service providers the power to veto the creation of new HMOs.

This Committee should recognize in the legislative history of H.R. 1 the extreme importance of encouraging free development of the HMO sector.

In view of the overriding importance of preserving opportunities for HMO entry, Congress should declare, either in legislation or in legislative history, that the law shall be administered with a view to this objective. Specification of the relevance of antitrust law and policy would be helpful in this regard.

Congress and this Committee should recognize that ease of entry not only enlarges opportunities for entrepreneurs interested in HMO formation but supplies a beneficial restraining influence on sellers already operating in the market. Thus, a market populated by only one or a few sellers may yet behave competitively, in part because sellers recognize not only their existing rivals but also the risk that other sellers will appear if prices rise, or quality of service sinks, to a level making entry appear attractive. For these reasons, preservation of such "potential competition"—which might come from HMOs operating in adjoining areas, employers interested in cheaper care for their employees or indigenous fee-for-service physicians—should be an important policy consideration.

A technical point: Clarification of the HMO membership requirements

There is a technical problem in the articulation of the membership requirements for HMOs in H.R. 1 and S. 1623. In H.R. 1 it is specified that at least half of the enrollees must be under age 65, and under S. 1623 at least half of the HMO's enrollees are required to be neither FHIP—nor Medicaid-eligible. These definitions should be altered to integrate them in such a way that an HMO could not be constituted with nearly half of its enrollees covered by Medicare and most of the other half made up of Medicaid (or FHIP) beneficiaries. The purpose should be affirmatively to require the HMO to serve a substantial population of enrollees who are non-federally supported subscribers who have chosen the HMO over the other alternatives available to them, including health insurance. Such a membership requirement would provide added assurance of the quality of care provided and would guarantee that the beneficiaries of federal programs would not be segregated in HMOs serving only or primarily publicly supported persons. Moreover, the statutory limitations to be imposed by H.R. 1 on the HMO's profit rate in serving Medicare beneficiaries require the presence of a substantial portion of non-federally supported individual in each HMO.

The CHAIRMAN. The next witness will be Dr. Kenneth O. Johnson, executive secretary of the American Speech and Hearing Association.

STATEMENT OF RICHARD J. DOWLING, DIRECTOR, GOVERNMENTAL AFFAIRS, AMERICAN SPEECH AND HEARING ASSOCIATION, ACCOMPANIED BY DR. F. T. SPAHR, DEPUTY EXECUTIVE SECRETARY, ASHA

Mr. DOWLING. Dr. Johnson is unable to be here today.

Mr. Chairman, I am Richard Dowling. With me is Dr. Frederick T. Spahr, deputy executive secretary of the American Speech and Hearing Association, a national scientific and professional society of more than 14,000 speech pathologist and audiologist members, with its national office in this city.

We are here today specifically to present the concerns of those of our profession who work with speech, language and hearing handicapped Americans over 65 years of age. National health surveys have shown that somewhere between 13 and 25 percent of all Americans over 65 have hearing losses severe enough sufficient to restrict the hearing of speech. Some 90,000 more have speech or language impairments—many such impairments are caused by cancer and many more by stroke.

The association comes before your committee to list four recommendations relative to the issues either contained in or prompted by your consideration of proposed 1972 amendments to the Social Security Act. These are summarized on the second page of the statement we have prepared for the committee's record. With your permission, I should like to summarize very briefly the last two of these recommendations and then turn to Dr. Spahr for an explanation of recommendations 1 and 2 which relate specifically to the delivery of speech pathology services to elderly Americans.

Mr. Chairman, the American Speech and Hearing Association believes that all providers of medical and health care services should be held accountable for the quality, utilization and costs of the services they render and that each profession should establish its own peer review mechanism.

So far as our own profession is concerned, we believe that local and regional peer review committees comprised of speech pathologists or audiologists should be created to review the respective services provided by medicare and other services to recipients. A move in this direction is presently afoot among the association's membership. We believe it and similar initiatives to be superior to a peer review concept which incorporates evaluation of a profession by individuals who do not possess indepth knowledge and skills in that profession.

This latter type of peer review we think cannot but lead to a significant reduction in the quality of services rendered.

We believe, as Senator Bennett said this morning during testimony offered by the Louisiana Hospital Association, that the professional services of doctors should be reviewed by doctors, and we think it follows reasonably that the other health care professions should have the same independence in their efforts to improve quality.

Senator BENNETT. Have you read my amendment?

Mr. DOWLING. Not the recent one, sir.

Senator BENNETT. Then you are not aware that this amendment provides that while physicians will have the ultimate responsibility for peer review, they are expected to contract with specialists in all other fields for review of related fields which are not directly a part of the practice of an ordinary physician.

Mr. DOWLING. Yes, sir; I understand that. I think we would question why physicians should have ultimate responsibility for review of speech pathology and audiology services.

Senator BENNETT. Well, there is a practical reason. We could have 50 or 60 review mechanisms set up to operate in each area and it would be almost impossible to operate that from Washington. But if we have an agency in my home city of Salt Lake with that responsibility of contracting with other disciplines for the review of service related to that discipline, the most obvious of which is dentistry, then it seems to me the Federal Government has one single agency to which it can turn rather than to be so badly fragmented that it would be impossible to keep any track from Washington of the kind of review service that is available.

Mr. DOWLING. Yes, sir; I do understand your concern and I am sure you understand ours. I think we have to take a close look at your proposal and I acknowledge we have not done that as yet.

Senator BENNETT. As I think has been made obvious from the discussion today, we don't want a series of protective unions; we don't want each group reviewing itself with no overview of the overall effect of the type of service that is being given to the patient.

Mr. DOWLING. Yes, sir. What we would like, and I am sure other health care professions would like, to insure, though, is that they have some input; and I couldn't speak to just what degree the input would be, insofar as your proposal is concerned, into the top level of the review organization.

Senator BENNETT. I think you might go back and reread the modern, the latest version of the amendment which I offered in January.

Mr. DOWLING. Yes, sir; we will do that. Thank you.

Turning now to the proficiency testing section of the proposal before your committee, section 241, our association would like to point out its belief that the section should and does relate only to medical and health care technicians who function under the supervision, direction, and prescription of medicine and other health care professions.

The association is concerned that the term "therapists" as used in section 241 may be generalized in administrative regulations promulgated by the Secretary of HEW so as to include speech pathologists. Any such application of the section would not be appropriate. Speech pathology professionals do not function under the supervision, direction, or prescription of members of any other profession.

I would like to turn to Dr. Spahr at this time, Mr. Chairman.

Dr. SPAHR. We are primarily here today, Mr. Chairman, to urge the committee to amend H.R. 1 so as to expand medicare coverage for speech pathology services provided in accredited, non-physician-directed clinics and by qualified private practitioners.

Current medicare coverage does provide for the coverage of speech pathology services when provided in approved hospital, extended care facilities, and home health agencies.

However, there is no provision for medicare coverage for the speech pathology services rendered in non-physician-directed clinics and by private practitioners.

Under part B of medicare I would point out that speech pathology services are covered if rendered in a physician's office under the supervision of the physician and incident to the physician's services. It is important here to note that speech pathologists do not render services under prescription by or under the supervision of physicians and very, very few speech pathologists are employed in physicians' offices.

Senator BENNETT. Who initiates the use of the services of a speech pathologist?

Dr. SPAHR. The referral source can be from physicians; many times it comes from social workers, from classroom teachers, and other professionals.

Senator BENNETT. Not for people over 65?

Dr. SPAHR. No, for people over 65 it would come from social workers, nurses, other health care professionals, including the physicians.

We believe that expansion of services under H.R. 1 would increase the accessibility of such services to elderly Americans as well as providing increased services to these individuals. All too often the elderly stroke patient must leave the hospital, extended care facility, or the home health agency with a lack of speech, with the inability to use words. They are not eligible for further services provided in the hospitals, home health agencies, or extended care facilities.

We also believe that our recommendation will reduce costs for services currently provided in the area of speech pathology.

At the present time the provider institution bills medicare and, in turn, must then provide reimbursement to the speech pathologist. Such administrative procedures add additional costs.

Although we do not have figures as to what the national costs would be for speech pathology services if medicare coverage were to be expanded, we would point to the example of the medicaid program in California. In 1970-71 fiscal year the estimated costs for services by health care providers was as follows: physicians, \$188 million; optometrists and opticians, \$12 million; speech pathologists, \$17,500. This gives some indication of the relatively low cost for and, utilization of, speech pathology services.

I would also point out that under the medicaid program in California that private practitioners are permitted to bill medicaid directly.

We would like to also address ourselves to a second point; section 251(c) of H.R. 1. This section relates to the reimbursement of contract providers for speech pathology services.

Last summer, Mr. Chairman, you received a letter from ASHA indicating our support of the salary-related concept for the reimbursement of services provided under contract. We urged that an equitable mechanism be established for reimbursement to providers, including payment for indirect costs. Since that time we are concerned that such an equitable mechanism may not be established and ASHA cannot at this time endorse section 251(c).

In October, the Bureau of Health Insurance of the Social Security Administration informed us of a proposal for controlling health care costs through reimbursement procedures. This proposal con-

tained several inequities, including a formula for reimbursement, the derivation of data for the formula, and the way in which indirect costs would be computed. You will find our concerns detailed in the full statement submitted.

We are most basically concerned about the need to control costs for speech pathology services under the medicare program.

In talking with the Bureau of Health Insurance representatives we were informed that they had received no reports concerning overcharges or other abuses by speech pathologists.

We are concerned that speech pathology services will be regulated when indeed a need has not been demonstrated for such regulation.

Likewise, such a control on reimbursement procedures will result in a decrease in services provided by speech pathologists.

We therefore urge the committee to either delete the entire section 251(c) of H.R. 1 or, at the very least, to exclude speech pathology services from its coverage.

The CHAIRMAN. Thank you very much.

Dr. SPAHR. Thank you.

(The prepared statement of Dr. Spahr and Mr. Dowling follows:)

STATEMENT OF THE AMERICAN SPEECH AND HEARING ASSOCIATION, PRESENTED BY DR. FREDERICK T. SPAHR, DEPUTY EXECUTIVE SECRETARY, AND MR. RICHARD J. DOWLING, DIRECTOR OF GOVERNMENTAL AFFAIRS

OUTLINE OF STATEMENT

The American Speech and Hearing Association recommends . . .

1. That Medicare coverage (under Part B of Title XVIII of the Social Security Act) be extended to include nonphysician-directed speech pathology services accredited by the American Boards of Examiners in Speech Pathology and Audiology or other accrediting agencies with similar standards.

2. That speech pathology services be excluded from Section 251(c) of H.R. 1, which relates to the establishment of guidelines for the ascertainment of reasonable costs for therapy services.

3. That all providers of health care services should be held accountable for the quality of services rendered, and that each medical specialty and health care discipline should establish its own peer review mechanism.

4. That quality-of-service considerations be accorded highest priority in the establishment of new proficiency testing criteria under Section 241 of H.R. 1.

ASHA AND THE SPEECH AND HEARING PROFESSION

The American Speech and Hearing Association (ASHA) is a scientific and professional society comprising more than 14,000 speech pathologists and audiologists. The speech pathology and audiology profession is the primary discipline concerned with the systems, structures, and functions that make human communication possible; with the causes and effects of delay, maldevelopment, and disturbance in human communication; and with the identification, evaluation, and rehabilitation of individuals with speech, language, and hearing disorders. According to national health surveys, it is conservatively estimated that between 13% and 25% of the population over age 65 have bilateral hearing losses of a magnitude sufficient to seriously restrict understanding of speech and, thus, seriously restrict social efficiency. An estimated 90,000 individuals over age 65 are speech handicapped. By 1980, this number is expected to exceed 148,000. Cancer is a prevalent condition among the elderly. Cancer can necessitate the removal of the larynx resulting in a total loss of voice. Strokes are also prevalent conditions among the elderly. Strokes often result in a significant reduction in language function (aphasia), which inability to comprehend and use linguistic symbols will result in an individual's ability to listen, read, write and talk. Loss of this ability can effectively produce severe social, emotional, and vocational handicaps.

It is true that some of these communication disorders go unperceived, and that many which are perceived go untreated. It is also true that the treatment of some of these disorders is administered by health professionals other than speech pathologists and audiologists. But the fact remains that a large number of elderly citizens are in some way and to some degree communicatively handicapped. Services to these Americans is a primary mission of ASHA and its membership.

It is our purpose here today to point up several of the problems of speech pathologists and audiologists relative to existing Social Security law and potential changes in that law contained in H.R. 1, with the hope that these problems can be resolved in the best interests of the professionals and the communicatively handicapped elderly citizens whom they serve.

MEDICARE COVERAGE OF ACCREDITED NON-PHYSICIAN DIRECTED SPEECH PATHOLOGY SERVICES

Currently, speech pathology services are covered under the Medicare program when the services are provided in approved hospitals, extended care facilities, or home health agencies. The services may be provided by an employee of the provider or by an outside source (agency, clinic, or independent private practitioner) under contract with the provider. Billing for services must be by the provider to whom reimbursement is made on the basis of reasonable cost.

For patients receiving care from a physician in his private office, speech pathology services are covered as incident to the services of the physician, provided they are furnished under the direct, personal supervision of the physician. Speech pathology services in physician-directed clinics are covered because such services are considered under the supervision of a physician. Billing must be made to the physician or physician-directed clinic.

It is important to note that there is precedent for Medicare coverage of non-physician directed services rendered by members of the speech and hearing profession. Current Medicare coverage extends to diagnostic audiologic services of certified audiologists, excluding examinations for hearing aids and other related services, such as educational training to compensate for loss of hearing.

Speech pathology services are not covered under the Medicare program when the services are provided by nonphysician-directed clinics or by independent practitioners, except under contract with provided institutions. Because a significant portion of speech pathology services for adults are provided in non-physician-directed clinics or by independent practitioners, speech pathology services are not available to many elderly citizens under the current Medicare program.

In the interests of the geriatric people of our country who have disorders of language and speech, the American Speech and Hearing Association recommends that Medicare coverage be extended to include speech pathology services provided by clinics that are not physician-directed and by independent private practitioners accredited according to standard of the American Boards of Examiners in Speech Pathology and Audiology or other accrediting agencies with similar standards, and that these sources of services be allowed to bill Medicare directly.

Implementation of this recommendation would provide increased services to the communicatively handicapped elderly citizens of our country as well as accessibility to such services. Many elderly citizens do not receive the services of speech pathologists because currently approved providers (hospitals, extended care facilities and home health agencies) have no speech pathologists on their staffs nor are there outside sources of service with which the providers can contract. Furthermore, speech pathology services cannot be obtained in many localities except through independent private practitioners.

Expansion of Medicare coverage to include speech pathology services of certified independent practitioners and accredited clinics that are not physician-directed would result in lower cost for these services. First, direct billing to Medicare by speech pathologists would eliminate the administrative costs of the provider. Under current procedures, a speech pathologist must bill the approved provider (hospital, extended care facility or home health agency), who in turn must process both billing to Medicare and reimbursement to the speech pathologist. Such administrative procedures necessitate additional costs. Indeed, administrative costs for speech pathology services have been reported to be as high as two to three times the fees charged by the speech pathologist. Secondary, services could be provided in environments with lower indirect costs. At the present

time, speech pathology services can only be provided in settings where there is a relatively high overhead. Community speech and hearing clinics, as well as independent private practitioners, have reduced indirect costs because patients do not require the extensive physical facility specifications, equipment, and variety of health personnel necessary in a hospital or extended care facility. (Virtually all accredited speech and hearing clinical facilities are non-profit, and are often subsidized in part by community funds, state and local governments.)

Most importantly, expansion of Medicare coverage to include services of non-physician-directed clinics and independent practitioners would result in increased social and emotional benefits for elderly citizens having speech and language disorders. All too often the elderly stroke victim is discharged from the hospital unable to talk. The individual does not require skilled nursing services and, therefore, is ineligible for the services of extended care facilities and/or home health agencies. The elderly citizen is often sent home to live a life of isolation and incapacitation because the individual cannot use the telephone, cannot talk with his friends, and cannot even make his most basic needs known because he is unable to speak the words.

PROPOSED GUIDELINES FOR REIMBURSEMENT TO THE CONTRACT PROVIDER OF SPEECH PATHOLOGY SERVICES

Senate Finance Committee deliberations during the Second Session of the 91st Congress on the House-passed version of H.R. 17550 resulted in a change in the House-approved limitation on reimbursement for institutional health related services from a "salary equivalent" to a "salary related" basis for physical therapy services. The change additionally extended the applicability of this limitation to other health related services, including speech pathology services, which may be provided in an institutional setting on a contract basis. The Committee gave as its reason for the change a need to control Medicare "program expenditures for therapy services and services of other health related personnel."

The House of Representatives, in the First Session of the present Congress, adopted your Committee's change, and in Section 251(c) of the legislation now under consideration (H.R. 1) proposed an amendment to Section 1861(v) of the Social Security Act "to limit payment for physical, occupational, speech, or other therapy services, or services of other health-related personnel . . . furnished by a provider of services or by a clinic, rehabilitation agency, or public health agency, or by others under arrangements with such a provider, agency, or organization. Such payment would be limited to the amount of salary which reasonably would have been paid if the services had been performed by an employee of such a provider or organization to provide such services) plus the cost of such other expenses incurred by the person performing such services on other than an employee basis as the Secretary may determine in regulations to be appropriate."¹

Last summer, in a letter to Chairman Long, the American Speech and Hearing Association agreed with the national need to control health care costs and recommended preservation of reimbursement for indirect costs incurred by the person providing services. In the same communication, ASHA expressed its concern that "reimbursement for services . . . be sufficient to cover costs in order to achieve effective delivery of speech and hearing services."² The letter further indicated that, under contractual arrangements, appropriate personnel salaries and overhead costs (e.g., travel-time expenses, office maintenance, etc.) must be taken into account when determining reimbursement for services.

ASHA reiterates its endorsement of what, in the mid-summer of last year, it interpreted to be the thrust of Section 251(c) of H.R. 1. But, because of a situation which has since developed, ASHA finds that it can no longer endorse the Section itself.

In mid-October of last year, the Division of Contract Operations of the Social Security Administration's Bureau of Health Insurance transmitted to ASHA its proposed guidelines for fiscal intermediaries to follow in determining the reasonableness of costs a provider incurs in furnishing physical, occupational, inhalation, or speech therapy to Medicare program beneficiaries under arrangement with self-employed therapists.³

¹ House Report No. 92-231, *Report of the Committee on Ways and Means on H.R. 1*, (92d Congress, 1st Session, May 26, 1971, p. 325.

² Letter to Senate Finance Committee Chairman Russell Long from Kenneth O. Johnson, Ph.D., ASHA Executive Secretary, August 6, 1971.

³ Part A Intermediary Letter No. 71, Bureau of Health Insurance (SSA), October 15, 1971.

The proposed guidelines, contained in what was called an "Intermediary Letter," were ostensibly developed by the Bureau in anticipation of final congressional approval of Section 251(c) in its present form. The Bureau invited the Association's comments on the substance and potential effects of the guidelines on the speech pathology profession and the speech-impaired recipients of its members' services.

The Association has since communicated with representatives of the Bureau on several occasions and conferred in person with staff members of its Division of Contract Operations. It is perhaps appropriate to note here that these representatives have shown themselves to be extremely forthright, genuinely interested in the concerns and positions expressed by ASHA, and at all times sympathetic to the needs of speech handicapped Americans and the profession dedicated to their service.

Yet, at this point in time, there has been no evidence indicating how or even whether the Bureau's proposed guidelines will be affected by the Association's comments. Therefore, ASHA feels compelled to register here the specific exceptions it takes to the guidelines.

First, the Intermediary Letter states the intention of the Bureau to use a formula for deriving an average hourly rate of compensation that is based upon a 40-hour week, under the apparent assumption that a full-time speech pathologist spends 40 hours in the actual rendering of service to patients. The formula, however, does not account for the time a speech pathologist spends in test interpretation, developing plans for treatment, charting patient progress, periodically reviewing patient progress with attending physicians and other health personnel, consulting with institutional staffs, etc.—all of which activities are required for participation in the Medicare program and are directly related to patient care. A clinical work day (i.e., direct patient contact) of the great majority of speech pathologists is five hours (25 hours per week), with the remainder of the professional's time spent as described earlier. What this illustrates, of course, is the apparent inapplicability of the Bureau's formula to speech pathologists.

The Bureau's Intermediary Letter additionally states: "Reimbursement for the services of a non-employee therapist may exceed 130 percent of the average hourly salary rate in the area where the provider established that the educational and experience qualifications of the therapist justify placing him in the upper end of the salary range for therapists of the same specialty in the area..."⁴

We are concerned that data on the weekly earnings of speech professionals, even at the "upper end of the salary range," may not include the fair and reasonable value of such factors as levels of professional education, number of years of professional experience, employment settings, etc. It is noteworthy that at least a Master's degree (or equivalent) is required for participation by a speech pathologist in the Medicare program.

Listed in the Bureau's Intermediary Letter are what have been viewed as "recognizable" (and, therefore, reimbursable—at least in part) costs a non-employee speech pathologist may incur while rendering services in a provider setting. The speech pathologist may accept a 30 percent standard allowance for these costs or, in the interest of equity, itemize them. The itemization option, in its present form, may be and has already been interpreted as requiring the speech pathologist to document all expense and fringe factors each time he submits a billing to a provider. Obviously, such a procedure entails additional, unneeded, and unwanted administrative efforts on the part of both the speech pathologist and the provider institution. In addition, ASHA maintains that the 30 percent is not representative of just compensation for the services rendered.

Federal agencies usually recognize an amount between 55 and 65 percent of personnel salaries as the indirect cost rate on federal grants and contracts.

A final concept contained in the Bureau's proposed guidelines deserves mention here—that of encouraging providers to seek "quantity discounts" from speech pathologists with whom they regularly relate.⁵ In ASHA's view, this concept is of inestimable merit where applied to ordinary business transactions and practices, but subject to serious question with respect to the rendering of health services. Here, cost for services should be relatively standardized along lines of types of services rendered and the severity of handicaps treated. Individualized treatment

⁴ *Ibid.*

⁵ *Ibid.*

to meet the needs of the patient and quality treatment must at all times comprise the hallmark of speech pathology services—not the number of individuals receiving these services in a given provider institution.

The American Speech and Hearing Association would like to reemphasize that it does not object to reasonable ascertainment of "salary related" costs for speech pathology services. But it takes very strong exception to guidelines for cost ascertainment which clearly overlook a professional's education, training, experience, employment setting, and related factors, and which apparently overlook the highly individualized needs of the speech handicapped persons served by such a professional. We are suggesting that in these respects, and most especially in the former, there is a very real distinction among the therapy services covered by Section 251(c) of H.R. 1 which is not represented in the guidelines proposed for the administration of that Section.

We also respectfully suggest, and perhaps most basically, that consideration be given to whether, in fact, there is any need at all for the Section's application to speech pathology services. The Section is designed to control Medicare program expenditures for therapy services, including speech pathology services, and to control abuse.⁶ Yet in our conversations and correspondence with Bureau of Health Insurance staff personnel, these spokesmen acknowledged that they were not aware of reports of excessive cost charges or any other abuses by speech pathologists.

Finally, and most importantly, ASHA believes that application of what it considers to be inequitable guidelines for determining the real costs of speech pathology services can easily result in the loss of these services to the Medicare-eligible individuals who require them. Unless guidelines are truly equitable, speech pathologists will simply be precluded, for reasons of economic reality, from Medicare-service provision. Thus, the guidelines would defeat the larger purpose of the program they are designed to help regulate.

Bureau of Health Insurance spokesmen have assured ASHA representatives that they will again consider whether any guidelines on reasonable costs for services should be made applicable to speech pathologists; whether, in the event applicability is deemed appropriate, separate guidelines should be developed or the present guidelines modified with respect to speech pathologists; and, in either event, what factors should compromise the guidelines.

ASHA strongly objects to the potential inequities resulting from Section 251(c) and urges either the deletion of the entire Section from the proposal now before this Committee, or, at the very least, the exclusion of speech pathology services from its coverage.

PEER REVIEW

ASHA supports the concept of accountability and believes that all providers of medical and health care services should be held accountable for services rendered. Accountability criteria should include quality, usage, and cost. In the opinion of the Association, "peer review" should be just that. Local and regional peer review committees comprised of speech pathologists (or audiologists) should be established nationwide to review speech pathology (or audiology) services provided to Medicare recipients and other consumers. ASHA, however, does not support a peer review concept which incorporates evaluation by individuals who do not possess in-depth professional knowledge and skills of the speech pathology and audiology professions. Specifically, ASHA does not support a peer review system incorporating review of nonmedical, independent health care providers by physicians. Further concern is generated by peer review proposals that are one-sided; physician evaluation of nonmedical health care services with no provision for evaluation of medical services by nonmedical health care providers. It is interesting to note in this regard that the American Medical Association has expressed opposition to both of these alternatives.

The American Speech and Hearing Association believes that the quality of health services should be reviewed by professionals defined as "peers." Thus, each profession should establish its own peer review mechanism. This concept is longstanding in the tradition of our country—professions themselves should continue to be held accountable for services given by their members.

PROFICIENCY TESTING

The American Speech and Hearing Association has long been an advocate of quality care for health services. Certainly, quality services may be provided

⁶ House Report No. 92-231, *op. cit.*

by some individuals not possessing formalized educational experiential qualifications. However, such individuals must meet the same standards of quality required of individuals who do possess formal educational and experiential credentials. Therefore, proficiency examinations must identify those individuals possessing sufficient knowledge and skills to ensure high quality services. We believe that Section 241 of H.R. 1, related to proficiency testing, is vague in this regard. The proposal includes proficiency without mention of quality. Therefore, the American Speech and Hearing Association urges the Committee to consider the concept of quality in developing recommendations for proficiency examinations.

Furthermore, it is clear that this Section relates only to technicians who function under the supervision, direction and prescription of the health care professions, primarily medicine. However, ASHA is concerned that the term "therapists," as used in the Section, may be generalized in administrative guidelines and regulations developed by the Secretary to include speech pathologists. Application of the Section to speech pathologists would certainly be inappropriate, because speech pathology professionals do not function under the professional supervision, direction or prescription of members of any other profession including medicine.

The CHAIRMAN. The next witness will be Hon. James E. Ross, chairman of the Beaver County Commissioners, Beaver, Pa., and I am pleased to see he is accompanied by Representative Frank Clark, of Pennsylvania, whom I will call upon at this point.

Mr. CLARK. Thank you, Mr. Chairman.

It is a pleasure for me to introduce the chairman of the county board of commissioners in Beaver County, who are the real owners or the operators of the Beaver County Home & Hospital, and they are going to speak to you today on the inequities of H.R. 1 in sections 207 and 225. Accompanying Mr. Ross and sitting beside him is the assistant administrator, Cosmo Morabito, and they are accompanied here in the room with the other two commissioners, Mr. Corak and Mr. Pettibon, who agree wholeheartedly with what the chairman of the board, Mr. Ross, will say to you.

I do appreciate your allowing me the opportunity to introduce these fine gentlemen.

STATEMENT OF HON. JAMES E. ROSS, CHAIRMAN, BEAVER COUNTY COMMISSIONERS, BEAVER, PA.; ACCOMPANIED BY COSMO MORABITO, ASSISTANT ADMINISTRATOR, BEAVER COUNTY HOSPITAL, PENNSYLVANIA

Mr. Ross. Thank you.

May it please the honorable committee, Mr. Chairman and members of the committee, my names is James E. Ross and I am chairman of the board of commissioners of Beaver County, Pa. On behalf of the citizens of Beaver County, I want to thank this committee for granting us the opportunity to appear before you to make the following brief statement.

The Beaver County Board of Commissioners are by State law charged with the responsibility of operating a long-term care facility for the aged and infirmed of Beaver County. The Beaver County Hospital is a modern geriatric facility caring for over 600 patients. It is recognized as one of the finest geriatric institutions in the United States. We in Beaver County are proud of the reputation our institution has gained nationally.

H.R. 1, however, contains two provisions which will be extremely detrimental to the operation of not only the Beaver County Hospital

but also all Government-operated long-term facilities in the United States. The provisions I am referring to are section 207 and section 225.

Section 207, as you all know, mandates a utilization review program or faces a 33 $\frac{1}{3}$ -percent decrease in Federal funds. The idea of utilization review to put people back into the community is a fine and commendable idea, but for a county facility it is not realistic, I know, after 12 years of experience as chairman of the board and a county commissioner and now going on for my 16 years on the board.

Utilization review in a county institution would be a study in futility. It would be entirely too costly with no benefits derived therefrom.

As you know, under utilization review, a facility must purchase the services of at least two physicians to conduct the review process. In the Pittsburgh area, the rate for a physician is \$50 per hour to utilization review. You can see that two physicians working 1 day would cost our county \$800. Eight hundred dollars represents over 40 days' complete care in our institution. I ask you, Is this cost control?

The real danger in this provision, however, is not utilization review per se, rather, the guidelines which could be established by the Department of HEW defining skilled nursing home care. Any time a cut-back in Federal funds was felt to be necessary, a new definition for skilled nursing would be developed and the number of patients eligible reduced.

We have seen this firsthand in the medicare program. Our institution went from 8.3 percent medicare patient days in 1967 to less than 1 percent medicare patient days in 1971. There was no dramatic improvement in health in Beaver County. It was simply stricter guidelines for utilization review promulgated by HEW.

We are now faced with the same possibility under medicaid. The results, however, would be far more tragic since even if the patient would be decertified, he could not be removed from the institution. The county hospital is the end of the line, and this goes for the 67 counties in Pennsylvania.

The county would have to assume an entire cost. Congress must realize the patients which are being cared for in county facilities are not there by choice. I repeat, they are not there by choice. They are there because they cannot care for themselves and either have no family to care for them or if they do, that family is unable or unwilling to accept the responsibility. It is the duty of government to see that our senior citizens in their declining years are provided with the best possible medical and nursing care. County governments will not shrink from this responsibility; but I stress, they cannot alone bear the entire cost for proper care and treatment.

Now let us consider section 225. This section limits payment for skilled nursing homes and intermediate care facilities to 105 percent of what the payment was for the same quarter of the preceding year. According to the House Ways and Means Committee report, there is concern that costs for skilled nursing homes and intermediate care facilities have been escalating at a rate which is undesirable from the standpoint of Federal, State, and local governments and the private sector.

We can assure you county government is concerned about costs. In Pennsylvania, for every 55 cents the Federal Government pays, county

government must pay 45 cents. We receive no title XIX medicaid matching funds from the State of Pennsylvania to operate our county facilities. Our State is derelict, in my estimation.

Section 207 does nothing to control costs; it simply lets the Federal Government retreat a little further from an unpleasant situation.

This section is discriminatory because it only applies to nursing homes. Why are hospitals and other providers of health care services not under the same restriction?

Let us consider costs in a county-operated skilled nursing home. Just like the general hospital, between 65 percent and 75 percent of all expenditures go to wages and fringe benefits; and, I might add, in the very near future we are facing this year unionization in this line of work that we are involved in.

We are mandated by the State of Pennsylvania as to the number of personnel which we must employ to operate our nursing services. In addition, many of these people are highly trained professionals and we are in competition with the general hospitals for their services. In order to compete, our pay scale and fringe benefits must be at least equal to that of the general hospital. If this provision is enacted, Congress will put the counties at a competitive disadvantage for quality personnel and professional services.

Gentlemen, in closing, let me point out that I do not ask for allowances from standards of professional care. I do not ask for variances in building construction requirements or life safety codes. I do not ask for the Federal Government to assume the entire cost of care. But when we have reached these professional standards, conformed to construction and safety codes and demonstrated our willingness to pay our fair share, I do ask that the Federal Government not renege on its obligation to the sick and needy of this country. This is what section 207 will do.

County institutions with the prodding and the aid and support of the Federal Government have raised their level of care far above and away from the stigma of the poorhouse and poorfarm. Do not make us cut services or pay substandard wages and return us to the poorhouse and the poorfarm. This is what section 225 will do.

I ask for the continued assistance of the Federal Government. Provisions for exemption from sections 207 and 225 must be granted to local government or there will be merely a shifting of the burden to the local government, a burden which, frankly, county government cannot afford and should not be forced to bear. And I might add right here, we have a total budget of operating the county of \$11.6 million; in this year \$3.6 million will go for the care of the aged in our institutions so we are trying to meet this obligation. This is a little over 3 mills of county tax and if we would lose approximately \$940,000 as proposed by sections 207 and 225, which would have to add another 4 mills to the existing tax burden in county government, and this would merely be a repetition throughout the 67 counties and I am sure, throughout the other 3,000 or more counties in the United States of America.

Why they are not here, I cannot understand, but we do have the full endorsements for our reason for being here from the County Commissioners Association and the secretary of health, education, and welfare of Pennsylvania.

In invite any Senator or Representative who does not feel that such an exemption should be granted to visit the Beaver County Hospital

and see for themselves the individuals who will be hurt by their actions.

Again, the county of Beaver is grateful for the privilege of your invitation and the opportunity to appear before you.

We completely endorse every other section of your particular bill. Thank you, gentlemen.

Senator BENNETT. Mr. Chairman, I just have one question.

I believe your 600 patients are there for custodial care only and how many of them are there because they are receiving medical attention?

Mr. MORABITO. About 100, sir.

Senator BENNETT. About 100 are there for medical only or for custodial care only?

Mr. MORABITO. Well, sir as far as custodial care goes, most of our—or all of our patients need some type of care. They are either a little mentally retarded where they can't exist out in the community, and they have—maybe they are bad diabetics where they can't take care of themselves—this type of patient. We have no—well, I won't say no—we have maybe four or five who could possibly be out in the community but the majority of our patients need some type of help. You know, they are old—

Senator BENNETT. Do you expect the majority of your patients will be there for the rest of their lives?

Mr. MORABITO. Yes, sir; they have no place to go and nobody wants them. This is the nature of the county institution.

Senator BENNETT. And this, of course, is not the type of patient that medicare is supposed to take care of? That is supposed to take care of a patient who needs medical services not simply a place to live and be fed.

Mr. Ross. Well, almost every one of these individuals receives medical attention there, they are sick, too. They are senile; some of them are retards. Most of them are senior citizens that hospitals will not take care of anymore and medicare has run out; and we have been meeting this need for them.

Senator BENNETT. Then what you need is not a skilled nursing home; it is a custodial, for many of these patients—for most of these patients it is custodial care rather than skilled nursing home care with the idea that having had that skilled nursing home care they move out?

Mr. MORABITO. Yes, sir; this is true, but it boils down to it is a matter of defining skilled nursing care and our type of patients need help; they need care of some sort. Either they need help in going to the bathroom; they need help feeding or they need injections; they need shots for diabetes and this type of care, where it cannot be provided in the home by the family because the family does not want to accept the responsibility, if there is any family; and foster homes will not cover the situation.

Senator BENNETT. I have no further questions.

Senator ANDERSON. You said this would be probably true for the rest of their lives. We were talking about catastrophic illness a while ago. I started as a young man when I was in another State because I had tuberculosis. Was that a catastrophic illness?

Mr. Ross. We have no tuberculosis.

Mr. MORABITO. We have no tuberculosis cases, sir.

Mr. Ross. The State does maintain a tuberculosis facility in the center part of the State and takes care of all the TB cases; no county is in charge of that responsibility anymore.

Senator ANDERSON. Well, we had some questions there about diabetes.

Mr. Ross. We have many patients with diabetes.

Senator ANDERSON. I have been taking insulin for 40 years. Was that a catastrophic illness?

Mr. MORABITO. The particular case I was talking about, sir, the patient was coupled with being mentally retarded. He has been in and out of our institution many times. Every time he leaves he completely goes off his diet and ends up in our institution, so these are, you know, the type of patients that medicaid title 91 is now assisting the county government in paying.

Senator ANDERSON. Thank you.

(The prepared statement of Mr. Ross and a communication related to Mr. Ross' statement follows:)

STATEMENT ON BEHALF OF THE COUNTY OF BEAVER, STATE OF PENNSYLVANIA,
PRESENTED BY JAMES E. ROSS

Beaver County is situated in Western Pennsylvania directly north of Pittsburgh. It is a semi-industrial county with a population of 208,418. Its largest city is Beaver Falls, which has a population of 14,375. The primary source of revenue to the county is, of course, the property tax. The present tax rate is 18½ mills based on 33⅓% of the assessed value of the property.

Our annual county budget is more than \$11,600,000.00. Beaver County is typical of most other counties in Pennsylvania in that it operates a long term care facility for the care of its elder citizens.

In 1956, a \$4,200,000.00 construction project on a new 400 bed institution was started. It was completed and opened in 1959. In 1963, realizing that the existing 400 bed institution was no longer able to handle the needs of our county, a 200 bed addition was added at a cost of \$1,500,000.00. This brings the total county government's investment in plant and equipment to \$5,700,000.00.

The institution today stands as a model for all county facilities. It enjoys a fine reputation in the community and in no way resembles the poor farm which was so prevalent among county institutions a few years back. So proud are we of our county institution, that in 1968, the name was officially changed from the Beaver County Home and Hospital to simply the Beaver County Hospital. We are approved by Medicare as an extended care facility and classified by the State of Pennsylvania as a skilled nursing home and as a general hospital.

We provide the following services for our patients: Special Dietary, Complete Medical Records, Full Time Medical Staff, Pharmacy, E.K.G., Ophthalmological Services, Audiology, Podiatry, Inhalation Therapy, Occupational Therapy, Speech Therapy, Recreational Therapy, Physical Therapy, Rehabilitation, Radiology, Laboratory, and Operating Room.

Beaver County Hospital—Financial summary

Cash receipts—1971:

Care and maintenance.....	\$1, 324, 000
Medical assistance (medicaid).....	950, 000
Medicare pt. A ¹	20, 000
Medicare pt. B.....	66, 000
Miscellaneous	40, 000
Total 1971.....	<u>2, 400, 000</u>

Cash disbursements—1971:

Salaries, wages and fringe benefits.....	2, 586, 000
Materials and supplies.....	895, 000
Capital improvements.....	121, 000
Total cash disbursements.....	<u>3, 602, 000</u>

¹ Pt. A cash receipts are down 77 percent from 1970.

Beaver County had to contribute from general tax revenues over \$1,200,000.00 to operate our county hospital. In addition, we submit the following statistics:

1. 1971 all inclusive cost per day, \$19.00.
2. 1971 average daily census, 522.
3. 1971 average daily Medicare census, 3.
4. 1971 average daily Medical Assistance patient, 348.

Note: The Beaver County Hospital has never had a retroactive denial on a Medicare patient.

With this background information in mind, let us now consider H.R. 1 and our specific objections to it.

Sections of major concern: (1) 207: Utilization Review; (2) 225: Limitations on Cost Increases.

Section 207 calls for a 33⅓% reduction in Federal funds to apply to those states which are not properly carrying out required utilization review and independent medical audit activities.

Studies by the federal government have supposedly revealed many patients in skilled nursing homes do not really belong there. We question these conclusions simply because the definition of a "skilled nursing home care patient" is quite vague, and definitely not easily understood at least in Pennsylvania. Consider this definition which is presently proposed:

"PENNSYLVANIA BULLETIN VOL. 1, No. 64 PROPOSED RULE MAKING

"3982. Determination of Need for Nursing Home Care.

"A person is considered to be in need of nursing home care if he is physically or mentally ill *and* undergoing planned, continuing medical treatment or palliative measures for the illness, which includes as an *essential* component the type of medical care provided by qualified nurses (registered or practical.)

"The need for residential or custodial care, or for supervision in taking routine medications or in the activities of daily living do not in themselves constitute a need for nursing home care.

"These services can be provided by other than medical personnel and in other than a medical facility, i.e. a nursing home. Need for nursing home care is distinguished from need from other types of care by the kind of skill required to provide the care; if the person's health needs require by order of his physician the services of a qualified nurse, the person is in need of nursing home care.

"Medical findings, and other information on physical condition are required for a decision. Need for nursing care and procedures must be supported by medical findings, and the frequency and regularity with which these services are needed must have a sound and reasonable basis."

As you can see, many different conclusions and assumptions can be made from the preceding statement. and depending on how big a cut back in funds was felt to be necessary, the federal government could be as lenient or as strict as they desired.

What really constitutes a skilled nursing home patient? Frankly, we cannot give you a stock answer. We will present three patient summaries taken from individuals on a skilled nursing floor in our institution.

First, let us consider staffing on this skilled nursing floor.

To care for sixty patients on a floor during the 7 a.m. to 3 p.m. work shift, we schedule (11) employees which we consider only adequate staffing.

Registered Nurse-----	1
Licensed practical nurses-----	2
Nurses aides -----	8
Total personnel-----	11

These eleven personnel must care for sixty patients. We submit three summaries of different patients, typical of the sixty on the floor:

"Patient A.

"Age: 91.

"Admitting diagnoses: Chronic Brain Syndrome, Senile Psychosis, Generalized Arteriosclerosis, Arteriosclerotic Heart Disease.

"Medication: Chloral Hydrate.

"NURSING CARE

"The patient requires complete bathing care and has to be fed. Patient is incontinent of bladder and bowels. She does not walk and has to be lifted up in

a geriatric chair daily. When in bed, patient assumes the fetal position. Does not communicate verbally with anyone. Patient cries and frequently you are unable to determine why. Patient requires siderails and restraints. Does not attend Physical Therapy, Occupational Therapy, or Recreational Therapy.

"HISTORY AND PHYSICAL EXAMINATION

"General appearance—thin, wasted, aged female, does not walk, says only a few words and unable to communicate.

"Eyes, Ears, Nose, and Throat: Early cataract.

"Mouth and Teeth: Grinds teeth constantly—dental caries.

"Cardiovascular: Systolic mitral murmur, no apparent enlargement.

"Chest X-Ray: Relatively normal chest.

"FINANCIAL AND SOCIAL SUMMARY

"Patient A's only source of income is her Social Security Check which she receives on her husband's account. She has no other assets available to her. Patient A's husband died two years ago. They had no children. Her nearest surviving relative is an 82 year old sister living 50 miles away.

"Patient B.

"Age: 80.

"Admitting diagnoses: Generalized Arteriosclerosis, Arteriosclerotic Heart Disease, Osteoarthritis, advanced disabling, Depressive Reaction.

"Medications: Peri-Colace, Gelusil, Senokot, Dalmane, Ritalin, Thorazine, Dilantin, Urobicotic, Loridine, and Perihemin.

"NURSING CARE

"Patient requires complete bathing care. She feeds herself and has to be assisted at times to dress. The patient walks with a walker and uses a wheelchair. Patient is incontinent of bladder and bowels occasionally. She is disoriented at times, excessive lethargy, very suspicious of everyone caring for her. She feels they are going to harm her. Sometimes refuses food or medication. Does not attend Physical Therapy, Occupational Therapy, or Recreational Therapy.

"FINANCIAL AND SOCIAL SUMMARY

"Patient B's only source of income is her Social Security Check. She has no other assets available. Patient B's husband has been dead for 19 years. She has six children ranging in age from 44 to 55 years old.

"Patient C.

"Age: 84.

"Admitting diagnoses: Chronic Brain Syndrome, Generalized Arteriosclerosis, Arteriosclerotic Heart Disease, Cardiovascular Renal Disease, Glaucoma right eye.

"Medications: Ritalin, Pavabid, Dorbantyl Forte, Pilocarpine, and NeoDecadron.

"NURSING CARE

"Patient requires complete bathing care, has to be fed and dressed. Patient is incontinent of bladder and bowels. She sits in a geriatric chair and ambulates with assistance for short distances. Patient is disoriented and unable to communicate verbally. Does not attend Physical Therapy, Occupational Therapy, or Recreational Therapy.

"HISTORY AND PHYSICAL EXAMINATION

"Her condition on admission was poor and her rehabilitation potential poor.

"OCCUPATIONAL THERAPY

"Ward visits for mental stimulation if not too confused.

"FINANCIAL AND SOCIAL SUMMARY

"Patient C's only source of income is her Social Security Check. On Admission, patient C had assets of approximately \$10,000.00 These assets were used

to pay for the first 18 months of care. Mrs. C has a husband who is 82 years old and three children ranging in ages from 45 to 55 years old."

None of the above patients presently qualify medically for Medicare. Under the proposed H.R. #1 Utilization Review standards, neither would they qualify for Medical Assistance.

We feel sure the Committee will agree that the staffing needed to care for sixty patients of this diagnostic type is not unrealistic. Therefore, if the federal government insists in cutting funds for the care of these patients, they should tell Beaver County what to do with Patients A, B, and C. Remember, they cannot be transferred to a lesser level of care because that means less personnel to care for them!

What about the cost of Utilization Review? It is predicted that it will cost some counties \$50.00 per hour per physician to Utilization Review. Further, it would be a complete waste of physicians time to do the review if the patient will not be discharged or taken out of the institution. Consider again patients A, B, and C. Where are they to go when decertified?

Conclusion: Utilization Review in itself may be a commendable idea of the federal government to get individuals back in the community, but for county institutions, it would be totally futile and financially disastrous.

Section 225 would limit payments to skilled nursing homes and intermediate care facilities to 105% of what the payment was for the same quarter of the preceding year.

This section is totally unbelievable. It's like Red China declaring war on Rhode Island. Nursing homes are not the cause of increased costs. They simply must follow what the general hospitals do. Besides, for the year ending September 30, 1971, hospital costs increased only 13.3% and with good financial management.

It would be possible to increase nursing home costs as much as 20 per cent a year under this provision.

Conclusion: The entire provision should be either dropped or a meaningful cost control provision should be written, encompassing all health care providers.

Sections of lesser concern

Section 230 provides for the elimination of requirements that states have comprehensive Medicaid programs:

Beaver County's position: This section should be eliminated or modified to provide that the states must continue to provide comprehensive programs.

Section 232 would permit the states to develop methods and standards for reimbursing the reasonable cost of inpatient hospital services.

Beaver County's position: This section should be eliminated. Methods and Standards for reimbursing reasonable cost should be the same under Medicaid as it is under Medicare.

Section 269 changes the requirements for Nursing Home Administrators.

Beaver County's position: This section should be eliminated. There should be no grandfather clause.

Addition to H.R. #1:

Section 1902(a) of the Social Security Act calls for the state to contribute up to 40% of the non-federal share. The Commonwealth of Pennsylvania does not now nor has it ever contributed any funds to county institutions in Pennsylvania. We strongly urge Congress to spell out this section more specifically and bring Pennsylvania into compliance with this section.

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF PUBLIC WELFARE,
Harrisburg, Pa., February 8, 1972.

Hon. RUSSELL B. LONG,
*Chairman, Finance Committee, U.S. Senate,
Senate Office Building, Washington, D.C.*

DEAR SENATOR LONG: The Honorable James E. Ross, Chairman of the Beaver County Board of Commissioners, has asked me to review his statement before the Senate Finance Committee concerning H.R. 1 on February 8, 1972.

I should like to add to his testimony the comments of the Pennsylvania Department of Public Welfare.

Mr. Ross raises objections to Sections 207 and 225 of the proposed legislation. Section 207 would create incentives for states to contract with health mainte-

nance organizations or similar facilities and disincentives to discourage prolonged stays in institutional settings. In general, the Department of Public Welfare favors increased reimbursement for health maintenance organizations. We firmly believe that this approach offers the best solutions to the problems of spiraling health care costs.

Since Pennsylvania has an effective program of controls over utilization of intermediate care and skilled nursing care facilities, the provision for reduction of the Federal financial percentage by $\frac{1}{3}$ after the first 60 days of care should have no effect upon us. Similarly, we have no objection to the granting of authority to the Secretary of Health, Education and Welfare to compute a responsible cost differential for reimbursement purposes by the skilled nursing homes and intermediate care facilities.

We do, however, have strong objections to the provisions in H.R. 1 which would decrease the Federal medical assistance percentage by $\frac{1}{3}$ after the first 60 days of care in a general or T.B. hospital and which would decrease the Federal share by $\frac{1}{3}$ after 90 days of care in a mental hospital. We also object to the discontinuance of Federal participation in the cost of mental health inpatient services after 365 days of such care during an individual's lifetime.

Although our stance is not in complete conformity with that of Commissioner Ross, I think our objectives are the same. We hope that H.R. 1, in whatever version it is passed, will provide increased service at lower costs to the states. We think the sections to which we have raised objection above vitiate this intent.

Sincerely yours,

HELENE WOHLGEMUTH.

The CHAIRMAN. Frances E. Fisher.

STATEMENT OF MISS FRANCES E. FISHER, AMERICAN DIETETIC ASSOCIATION; ACCOMPANIED BY MRS. LOIS EARL, NUTRITIONIST, WASHINGTON, D.C., MEMBER, ADA

Miss FISHER. Mr. Chairman, I am Frances Fisher, a registered dietitian and associate professor of Case Western Reserve University in Cleveland, Ohio. I also serve as the chairman of the Advisory Committee on Legislation and Public Policy of the American Dietetic Association. It is in that capacity that I am presenting testimony today.

I am accompanied by Mrs. Lois Earl, a nutritionist in the District of Columbia Department of Human Resources, and a member of the American Dietetic Association.

First of all, I want to express the appreciation of the association for this opportunity to present its views. The American Dietetic Association has a membership of approximately 23,000 dietitians and nutritionists who have as their objective the improvement of nutrition of human beings and the advancement of the science of dietetics and nutrition, as well as education in these and allied areas.

In recent years the public awareness of the importance of nutrition to health has increased sharply. In 1967, the Congress approved legislation that authorized a national nutrition survey. Subsequently, the Senate established a Select Committee on Nutrition and Human Needs. In 1969, President Nixon sponsored the first White House Conference on Food, Nutrition, and Health. Congress has also expanded and improved the food stamp program and the national school lunch program.

This progress is gratifying but much more needs to be done if we are to maximize the contribution of nutrition to the health of our citizens. The legislation under consideration today—H.R. 1—offers a substantial potential for achieving such an objective.

In the interest of saving the time of the committee, we will confine our remarks to two aspects of H.R. 1: the provisions relating to day care under the welfare reform proposal, and the provisions relating to home health services under the amendments to medicare.

Day care for low-income children actually dates back more than 100 years, when the State of Massachusetts showed concern. It was the need for physical care and protection of children in such centers that led to the first child development nursery schools in colleges and universities. Although day care centers were originally established primarily for preschoolers, the need today is for such services through elementary school age.

A recent report of the Department of Health, Education, and Welfare of the AFDC program showed that 80 percent of the women could not take jobs because they had children under age 8 at home, and more than 50 percent lacked child care facilities. If these mothers are to seek employment or training for employment, we must expand significantly our child day care resources. Such resources should be developed with emphasis on the child care development aspects of the programs as opposed to custodial care.

Vital components of strong day care programs for children are adequate housing, qualified teachers capable of carrying out a curriculum based on sound principles of child growth and development, qualified personnel to carry out a nutritional service and educational program and an educational program for the parents of children to carry into the home the learning effected in the day care center.

The detailed recommendations of the American Dietetic Association with respect to day care programs for children are attached in appendix A.

One of the important contributions of medicare is the stimulation it has provided to encourage the establishment of home health agencies. Home health care can reduce greatly the need for hospitalization and the cost of health care.

In 1963 there were only 250 agencies that would have qualified as home health agencies as defined in medicare regulations. As of January 1969, there were more than 2,100 agencies certified for participation under the program.

Under existing law, however, there is no provision for the reimbursement of the home health visits made by a nutritionist.

For effective medical care there must be a continuity of health services. Under medicare, however, this is not possible with respect to nutrition services. The full range of nutrition services is available to the medicare patient as long as he is in the hospital. Upon discharge to a home health agency, his eligibility for the services of a nutritionist through home health visits is denied under existing law.

Consequently, the American Dietetic Association recommends the enactment of S. 2504, that was introduced by Senator Humphrey, as an amendment to H.R. 1. S. 2504 would authorize reimbursement for the home health visits of a nutritionist.

There is more than enough professional and scientific support for S. 2504. Let me cite some of them.

A recommendation from the 1971 White House Conference on Aging reads as follows:

It is recommended that nutrition services and nutrition counseling be a required component of all health delivery systems, including such plans as medicare, medicaid, health maintenance organizations, home health services, extended care facilities and prevention programs.

A recommendation from the 1969 White House Conference on Food, Nutrition, and Health reads as follows:

We recommend that the services of a nutritionist should be made reimbursable under medicare, medicaid and other third-party payment programs and agencies.

The inclusion of nutrition as a component of home health care would significantly reduce the number of people requiring expensive hospitalization under medicare. As Dr. Jean Mayer, Chairman of the White House Conference on Food, Nutrition, and Health, recently stated:

With government at all levels responsible for an ever-increasing proportion of health expenditures, with these expenditures mounting without appreciable effect on the health statistics of the nation, it is becoming obvious that emphasis must be shifted from purely curative to prevention and rehabilitation. This means that nutrition should assume even more importance than in the past. In terms of money, as in terms of human suffering, one can well argue that every dollar spent on nutrition instruction may save tens of dollars in later medical care.

The American Dietetic Association's position paper on the role of nutrition in the delivery of health services is attached as appendix B.

We understand that the Commissioner of the Social Security Administration has objected to the enactment of S. 2504 on the basis of cost. Unfortunately, his Administration is more insurance oriented than health oriented. On the basis of studies and research, we estimate that nutrition services are indicated in 90 percent of the patients under treatment in home health agencies. However, not all of these patients would require the services of a registered dietitian.

There are some 20 to 25 percent of the patients served by home health agencies, however, whose nutritional needs would best be served by a registered dietitian. To some extent these patients are seen by other types of health personnel who are employed by home health agencies. Some home health agencies employ dietitians under the administrative costs of the agency. Such dietitians may serve as advisers or consultants to nurses and other agency personnel. Provision should be made, however, for direct services to patients by dietitians.

There are some patients who have what might be termed "catastrophic illnesses" in which nutrition is of great importance. The specific diet prescribed for the patient on kidney dialysis is restrictive and difficult for most patients to follow. However, it is of great importance in the total care of the patient.

Close and continued followup of these patients by a dietitian would be advantageous. The patients with certain types of chronic heart or liver diseases for whom lifelong, stringent dietetic care has been prescribed would also benefit from direct services from the dietitian. Following radical surgery of the gastrointestinal tract, nutritional care is of importance. If the patient's health is to be restored and maintained, his eating pattern must be carefully planned to provide for absorption of sufficient nutrients with the limited absorption area remaining.

Nutrition care, including home visits for patients such as those described above, could in fact be a factor in reducing hospitalization and therefore in reducing cost of care of those patients.

We would like to point out, however, that the enactment of S. 2504 would not increase the limit on the maximum number of home health visits permitted under medicare. Home health visits of a nutritionist would be made only on the order of a physician and not on a routine basis to every patient.

We are convinced that the enactment of S. 2504 would reduce costs under medicare through decreases in the need for hospitalization. This has been demonstrated in studies financed by the Public Health Service.

The development of sound nutritional habits is recognized as a component of both preventive and restorative health programs. For this reason we support legislation that will implement such programs both in day care and medicare.

Thank you very much.

Senator BENNETT. I have no questions.

Senator ANDERSON. If there are no further questions, we will adjourn until 10 o'clock tomorrow.

Mrs. EARL. I would just like to reinforce the reduction of costs of hospitalization that might occur where the dietitian's services would be available to—directly to the patients. Over and over again we find often the cardiac, the diabetic or the patient with multiple complications of disease being sent back to the hospital because the dietary prescription is not followed; and with the direct contact of the patient and the dietitian we find that the education is advanced and that the patient is able to maintain himself much better, eat the food that is prepared, because he knows and understands exactly the relationship of the diet to the disease.

Senator ANDERSON (presiding). Thank you very much.

(App. A and B submitted by the previous witness, Miss Fisher, follows:)

APPENDIX A

THE AMERICAN DIETETIC ASSOCIATION POSITION PAPER ON FOOD AND NUTRITION SERVICES IN DAY-CARE CENTERS¹

The American Dietetic Association, in commitment to its responsibility for promoting optimal nutritional status of children, recognizes the urgent need for adequate food and nutrition services in all day-care centers. In fulfilling this commitment, the Association—

(a) Supports the recommendations for day-care set out in the Final Report of the White House Conference on Food, Nutrition and Health, 1969.

(b) Recommends that day-care centers—

(1) Provide food that is adequate in quantity and quality to supplement food served at home in meeting the total nutritional needs of the child.

(2) Provide food with consideration for cultural patterns, food practices, socialization, and developmental needs of children and their families.

(3) Provide an enriching experience in nutrition education for children and counseling to parents regarding food and nutritional needs of their children.

(4) Provide food and feeding in a safe, clean, and pleasant environment.

(c) Recommends that a nutritional assessment be an essential part of health evaluation of children admitted to day-care.

(d) Recommends that nutrition education and food service management be an integral part of continuing staff in-service training.

(e) Supports sound legislation and programs that promote or provide for food service and nutrition education in day-care centers.

(f) Takes the position that all day-care centers should be licensed by an official regulating authority.

(g) Takes the position that the development of food and nutritional standards for day-care centers must be under the leadership of a qualified nutritionist(s) or dietitian(s).

(h) Takes the position that all agencies charged with the responsibility of regulating and enforcing food and nutritional standards in day-care centers must employ professionally qualified dietitians or nutritionists who function at the administrative and policymaking level in discharging this responsibility.

(i) Takes the position that all day centers having food service or nutrition education programs must have the services of a professionally qualified dietitian or nutritionist on a full-time or regularly scheduled basis.

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APPENDIX B

THE AMERICAN DIETETIC ASSOCIATION POSITION PAPER ON THE NUTRITION COMPONENT OF HEALTH SERVICES DELIVERY SYSTEMS²

"One of the main problems resulting from the lack of nutrition training in the nation's medical schools is that however much individual physicians in the federal or state planning agencies may protest their interest, nutrition almost invariably ends up being left out as a component of health-care delivery systems. Indeed, less than two years after the White House Conference on Food, Nutrition and Health, the two strongest nutrition bureaus at the state health level (New York and California) are threatened with extinction.

"With government at all levels responsible for an ever increasing proportion of health expenditures, with these expenditures mounting without appreciable effect on the health statistics of the nation, it is becoming obvious that emphasis must be shifted from purely curative to prevention and rehabilitation. This means that nutrition should assume even more importance than in the past. In terms of money—as in terms of human suffering—one can well argue that every dollar spent on nutrition instruction may save tens of dollars in later medical care.

"I am delighted to see that The American Dietetic Association has again asserted its leadership in human nutrition by preparing and endorsing a position paper which outlines clearly the necessary nutrition services to be included in comprehensive health schemes. The paper also clearly describes the need for nutrition input at the planning stages if nutrition services are to be properly structured. At present, the United States Department of Agriculture is operating a gigantic (over \$3 billion) food program with what many think

¹ Approved by the Executive Board, April 20, 1971, as Position Paper Number 0000G

² Approved by the Executive Board, February 12, 1971, as Position Paper Number 0000E.

is much too small a nutrition component. Present indications are that the Department of Health, Education, and Welfare is similarly casual about nutrition. I commend this position paper to health planners at all levels"—*Jean Mayer, Ph.D., D.Sc., A.M. (hon), M.D. (hon), Professor of Nutrition, Harvard School of Public Health, and Chairman, White House Conference on Food, Nutrition and Health.*

"Nutrition services under the supervision of qualified nutrition personnel should be a component of *all* health and health-related programs and should be designed to reach the total population with priority given to such nutritionally vulnerable groups as infants, children, and youth in the growing years, women in the child-bearing years, and the older age population." (1) The need for the Association to interpret and expand this policy statement is based on a recognition and concern that:

(a) The need and demand for quality health care by the population is not being met by, and is critically straining, the current health care delivery system.

(b) The alarming increase in the cost of medical care mandates a review and evaluation of the present health care delivery system.

The American Dietetic Association's position is that inclusion of nutrition as a component of health care will significantly reduce the number of people requiring sick care service and, therefore, contribute directly to—

(a) A relief of strain on the nation's health care delivery system;

(b) A decrease in the escalating rate of health care costs;

(c) An increase in physical, mental, and social well-being of people so that they may achieve and maintain productive and independent lives.

Nutrition is a critical factor in the promotion of health and prevention of disease and in recovery and rehabilitation from illness or injury. Evidence mounts that Americans who fail to attain a diet optimal for health can be found at every socio-economic level. The reasons are many and complex, but the impact on the health of the nation is seen in the increased risk of complications of pregnancy in the poorly nourished woman, in the chance that her infant may be of low birth weight with accompanying risk of retarded physical and mental development; in the high incidence of overweight and underweight in school-age children and in adults; in the debilitation of the malnourished elderly; in dental disease, widespread in the total population; and in the high incidence of chronic illnesses that require dietary treatment, monitoring, and follow-up. Since it is apparent that improvements in the nutrition of people will have a direct effect on the level of health services. The American Dietetic Association recommends the following:

I. Nutritional care, as a component of health care, be available to all people on a continuing and coordinated basis. *Nutritional care* is the application of nutrition science to the health care of people. In its broadest sense, nutritional care is provided to the general population through studies of food consumption and nutritional health, mass education, and food assistance programs. As applied to patient care, it has the same components (assessment of food practices and nutritional status, nutrition education, and food assistance) plus dietary counseling and the service of appropriate food. These nutritional care services must be combined and coordinated to meet individual needs.

II. Nutritional care be integrated into preventive, diagnostic, curative, and restorative health services. Any contemplated health services delivery system should include a nutrition component in its preventive as well as remedial services, if the maximum benefits to health are to be achieved. The following example illustrates the application of this recommendation:

HEALTH SERVICES

NUTRITIONAL CARE

Public health service—health promotion	Mass nutrition education; supplemental food assistance
Health-testing service (7)	Assessment of food intake and other indexes of nutritional status
Health care service	Nutrition education and counseling, food assistance, appropriate food service
Preventive maintenance service	Dietary counseling, food assistance, appropriate food service
Sick-care service	For all levels of in-patient care, appropriate food service, diet therapy, dietary counseling

Mass nutrition education ; supplemental food assistance

Assessment of food intake and other indexes of nutritional status

Nutrition education and counseling, food assistance, appropriate food service

Dietary counseling, food assistance, appropriate food service

For all levels of in-patient care, appropriate food service, diet therapy, dietary counseling

III. The planning and supervision of nutritional care be under the direction of persons professionally educated in nutrition as it relates to human health needs. Dietitians and public health nutritionists, with their educated knowledge of foods and nutrition, are the health professionals who are prepared specifically to help individuals and groups improve their diets and their nutritional status. (In this paper, the term *dietitian* shall be interpreted to mean either a public health nutritionist or a dietitian who is qualified for registration in The American Dietetic Association.) Supportive personnel (dietetic technicians, dietetic assistants) extend the knowledge and skills of dietitians to greater number of people.

IV. Dietitians function at the planning and policy-making level of federal, regional, state, and local comprehensive health planning bodies to assure that an appropriate nutritional care component is incorporated into all comprehensive health care planning.

V. Comprehensive health care plans include appropriate administrative placement of the nutrition care component; staffing patterns and qualifications for personnel; identification of nature and extent of nutrition problems; standards of nutritional care; methods to be used for delivery of nutrition services; and evaluation.

VI. To assure that a supply of dietitians is available and accessible to those in need of nutritional care, steps should be taken to—

A. Support the expansion of existing education and training facilities in nutrition and dietetics and the development of new facilities.

B. Increase support available to students of education and training in nutrition by means of scholarships, loans, and other financial mechanisms.

C. Explore and establish new approaches to undergraduate, graduate, and technical education.

D. Utilize supportive dietetic personnel and improve their career development and status in the health care system.

E. Explore other means to increase the dietetic manpower supply through such mechanisms as proficiency and equivalency examinations and other recruiting efforts.

VII. Dietitians be eligible for payments as providers of health care services. Future health care legislation should stipulate dietary counseling services as an eligible service for third party payment.

VIII. Adequate funding for preventive as well as curative nutritional care services be provided. Until such time as the nation is geared to deliver comprehensive family health care, nutrition services should be supported in existing specialized programs and services, such as: health services for mothers and children; the elderly; special groups, such as migrant agricultural workers and low-income families; family planning programs; chronic disease control services; home health services, rehabilitation services for drug and alcohol addicts; and group care services in facilities such as hospitals, nursing homes, extended care facilities, day-care centers, and residential institutions; detention centers, detoxification centers, and prisons.

XI. A careful appraisal be made of the economic benefits of nutritional care in a comprehensive medical care system. Such an appraisal should also include evaluation of the effectiveness of preventive nutritional care, as well as remedial services, on such variables as cost, absenteeism, worker productivity, and so on.

X. Any national health insurance program adopted include incentives for the development of preventive health services. Nutritional care should be identified in the legislation as an essential component of preventive health care service.

XI. Standards for nutritional care services be included in all federal and state guidelines and regulations for health care.

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ASSOCIATION REPRESENTATIVE TESTIFIES AT AGING HEARING

In representing The American Dietetic Association at a regional hearing in Chicago on March 11, in preparation for the White House Conference on Aging in November, Ruth M. Yakel, A.D.A. Executive Director, quoted from the above position paper and from the A.D.A. position paper on aging. In amplification, she offered some concrete comments and recommendations, saying in part:

Since the Association was founded in 1917, the membership has been engaged in a number of projects and services related to the nutrition of the elderly. The list would be long, and our interest has not waned.

I should now like to comment on present volunteer nutrition education activities of the national and state dietetic associations. For example, a variety of projects and activities are related to the nutrition of the elderly. The Washington State Dietetic Association has cooperated with the Washington State Council on Aging in developing nutrition education materials for distribution to senior citizens' centers, and members of our Association also provide individual and group counseling at these centers. Tennessee and Oklahoma have also reported activities related to nutrition education with senior citizens.

At the national level, an invitational conference on nutrition services in primary health care is being planned to help identify the role of the dietitian and nutritionist in such settings as group and family practice, health maintenance programs, neighborhood health centers, and other ambulatory care settings. Current trends and contributions in home health services will also be discussed. We would anticipate that this conference will have an impact and be a motivating force encouraging participants to apply and practice knowledges and techniques gained to new health services for the elderly.

With the extension of the Food Stamp plan in 1970, the elderly may now purchase home-delivered meals with food stamps. With the probability of many new organizations going into the business of home-delivered meals, we would urge adoption of certain standards. These would include: a home-delivered meal should provide a minimum of one-third of the daily requirement in calories and nutritive values needed by the elderly; the food should be prepared and served under sanitary conditions, e.g., temperature and equipment for holding and de-

livering the meals should be defined; and the food and the meal delivered should be of good quality. The elderly consumer needs such regulations for protection of his health, as well as value for the cost.

Use of the facilities of neighborhood health centers, community centers, churches, and schools as sites for meal functions and the service of nutritionally adequate low-cost meals for the aging should be further encouraged. Restaurants in some communities might also serve as centers. The importance of sociability and the psychologic effect of mealtime cannot be overemphasized.

Because of limitations that come with aging, multiple forms of assistance are needed by the elderly. Generally, there is no money for such services; hence, the use of volunteers has been the answer in some cases, but this is not a completely satisfactory answer. Since our main interest is food for the aging, we pose the question; What can be done to provide for the home-bound elderly—the individual who is unable to leave his home because of physical limitations and thus cut off from the outside world? What can be offered to the reasonably well elderly person without transportation? Stores are not always readily accessible, and if they are, can the elderly walk that far and then carry the groceries back to their rooms, apartments or homes? A fee food delivery service would be a tremendous contribution to thousands of elderly persons who wish to retain some independence. Special taxi or bus schedules and special store hours to permit the elderly to do their own shopping would also be of assistance.

In conclusion, I would reiterate the Association's position that nutritional care should be available to the elderly on a continuing and coordinated basis. Improvements in nutrition have direct effects on the level of health and the resulting need for health services.

The Association would further encourage the provision of adequate funding for preventive, as well as curative nutritional care services. Until such time as the nation is geared to deliver comprehensive health care, nutrition services need to be supported in existing and new specialized programs and services to the elderly.

Senator ANDERSON. We will recess until 10 a.m., tomorrow morning. (Whereupon, at 12:15 p.m., the hearing was adjourned, to reconvene at 10 a.m., Wednesday, February 9, 1972.)

SOCIAL SECURITY AMENDMENTS OF 1971

WEDNESDAY, FEBRUARY 9, 1972

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10:05 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Byrd of Virginia, Nelson, Curtis, Jordan of Idaho, Fannin, Hansen.

The CHAIRMAN. The hearing will come to order.

The first witness this morning will be the Honorable Mike Gravel U.S. Senator from Alaska.

Senator Gravel, we are very proud to have you here with us today and we will be happy to hear your statement.

STATEMENT OF HON. MIKE GRAVEL, A U.S. SENATOR FROM THE STATE OF ALASKA

Senator GRAVEL. Mr. Chairman, I am very happy to be here and, as you know, I hold you in very high personal affection and so I appreciate the opportunity—

The CHAIRMAN. It is mutual.

Senator GRAVEL (continuing). The opportunity on the last day of the hearing to come before you and before your committee.

I have an outline of some facts relative to what would occur under H.R. 1 in Alaska, which I think is of devastating proportion. It would increase the State's costs by \$21 million; and for a small State like Alaska, this 386-percent increase in State costs is quite a change in our welfare cost, and I don't think, in reality, the State can afford it.

We hear a lot said about how we have acquired \$900 million from an oil lease sale, but one of the problems that we face with the delay of the pipeline is that we do not have the funds to satisfy many of our social needs even though we have raised the cost of the State budget. At the present rate, unless we cut back drastically (we will have used up our entire \$900 million legacy in 3 to 4 years. That would mean that we would have a State operating at a level we could not sustain.

So you couple this problem with the welfare changes that could take place and we come to a very serious situation. So I only ask the committee's consideration—I submit this outline for the record.

The Governor of Alaska, William Egan, a good friend of mine, has also submitted an 18-page statement which goes into great detail in this regard, so I would ask the committee to look at it very thoroughly.*

*See p. 2002.

Senator GRAVEL. Now, Mr. Chairman, I wish to speak with a broader scope. Among my papers that I took for the Christmas holidays was a copy of the speech on welfare reform, H.R. 1, which you delivered on the floor just before the session adjourned. I took that because, having heard you privately, I knew your strong views and I knew your expertise in this area; and I read over—in the course of writing a book that I will have published later this year—I read over your statement and I found that I agreed with it almost 99 percent. I disagreed with one point which was, I think, very fundamental, and that is the reason I wanted to come before the committee and yourself to see if I could make some minor contribution to the philosophical approach to it all; and that is, of course, where my book addresses itself—to the philosophical questions, because I don't think I can match your expertise in the details.

My knowledge and time would not permit competition with you and other members who are expert in the field. I was struck by the validity of your entire argument in your statement.

You raised the point, and properly so, of the cost involved of doing this, and it was a sizable cost and one that makes a person sit up straight and say, "My God, what's happening to our society if this is what it is going to cost us to undertake these programs?"

So I started analyzing the cost and analyzing what I thought was involved in the attitude in our society toward welfare, and I came to this conclusion: Why do we pay welfare to begin with? We pay welfare because we have a social conscience; we don't want people to starve to death in the country. That is why we do it.

Now, if we look to the basis of this and say, well, if we have this social conscience and if we have the money to do this, then should we have a hangup with respect to the work ethic. Our ability to pay welfare is dependent upon the total affluence of the United States of America.

If you made a comparison and said, let's look upon this as a normal corporation and every single citizen in this country is a member of this corporation, that would mean he is a stockholder in the corporation; whether or not he works or not, he is a stockholder and, therefore, as a stockholder in this country he is entitled to a dividend if the corporation is prosperous and doing very well.

Well, obviously, we think the corporation is prosperous enough to pay some amount to people in the lowest income levels of our society. So if we took a different view and said we are not talking about "welfare," and if we didn't have a hangup about giving something for nothing, we could take the attitude that this is an affluent society and that we are giving only something which is basically their due as members of society. That would allow a great breakthrough in the use of the money.

I was reminded that I, too, have the same attitude toward work. I find myself an industrious worker. I think anybody who is in the Senate would have to be an industrious worker or he wouldn't be in the Senate, because it takes a certain amount of push and effort; and I look at another person and I say, why doesn't he work as hard as I do? Obviously there are many reasons—physiological, social, environmental, purely physical or psychological—but for many reasons they may

not have the same attitude I have toward work. So I find myself being trapped into what the administration, the President, termed the work ethic and what we call workfare, and that is that we won't pay anybody who is poor any amount of money unless we have testimony or proof that he is willing to work—well, that is very good because that means that we look upon work as a virtue.

Well, I do, and I think we all do.

If that is the case, then how can we in justice turn around and permit a person to clip coupons or collect dividends when he does no work? And so, if we are to be equitable in our society we would have to say if we are going to force the poor people to work—and thus force virtue upon them—in order to receive the returns from a prosperous society, then we should at least be honest and turn around and force virtue upon the people in our society who clip coupons or collect interest without lifting a finger.

If I inherited \$10 million today and didn't do another lick of work the rest of my life, then, obviously, I would have deprived myself of the virtue of work. So if we look upon work as virtuous and something that we feel should be forced upon the poor, tying it to what they should receive from an affluent society, then we should, in my opinion, do the same thing to the rich and not let anybody—not just or necessarily the rich—anybody collect income for which he has put forth no effort. Then, obviously, we should require that in order to get interest, in order to get unearned income, he should have to go to work for it. Then I think we would be consistent.

Obviously, in such an effort to be consistent we begin to realize that forcing people to acquire this virtue is not possible because you can't legislate morality, and I think that is something that we in the legislative positions learned some time ago: you can't make people virtuous; they are either virtuous or they are not virtuous; so you have to look at it from another approach, and I think we should look at it from the approach that people are drawing dividends and that we are going to apportion a certain amount of wealth to them. Of course, we could pay the dividend to everybody because it is the total product of society, but since we are approaching something we don't really know too much about, I think all we can do is experiment, and to pay this dividend only at the lowest level. I am realistic enough to think that at this stage of the game the committee will not alter drastically the approach it has in hand.

So I only come forward with some broad philosophical lines.

Let me just suggest this possibility—and I have done the arithmetic and can submit it for the record. If we lump together social security, welfare, and raise welfare to the point of \$2,000 per person, and cease to call it welfare but call it a citizen's wage or a citizen's dividend for simple membership in the United States of America, the arithmetic comes out—assuming we had a tax reform—to be only about \$15 billion more than we pay today for our social security and present welfare. And to think we would place a base in our society that fundamental—you can begin to see that part of the economic problems we face today is a lack of consumption.

What would be the increased consumption from placing a floor in our society? You would create a pattern of consumption that would exceed the present activity by manifold.

Secondly, you would add an element of freedom to the present situation in labor; and here it is very simple. If we have greater mobility, greater choice, we have a chance of providing greater productivity. I happen to think that rather than rail against our corporate society, I think it is the most effective tool we have in our society; and we impede its effectiveness when we work against its normal efficiencies, what we call featherbedding.

The reason why we have featherbedding is because when you throw people out of work they have got no income, so we develop this whole attitude that we have got to create jobs. What is the use of creating jobs if we don't need the jobs? If we don't need the work, if the machines can do it, we ought to be intelligent enough to just turn around and let the machine do it and sit back and clip our coupons from it.

But this cannot happen as long as we maintain a psychology that you have to work whether you like it or not because we think it is good—work is not good; work is only good if it is interesting and enjoyable, and if it does not meet that definition then we should be at a headlong pace to do away with the rest of the situation and not forcibly provide for work.

We can't do it because we are locked in on a trajectory in which we don't have a way of passing out the dividend to people in an honest fashion. So then the only way we have to do it is to force them into work situations which may or may not be productive, and which may or may not be efficient.

Just take our situation in government where we have a program to create public service jobs. This does not mean they are needed. We presume that they are needed and yet one of the problems of bureaucracy is its great inefficiency and the great number of people who are employed, like the Communist system, which have a vested interest in the total inefficiency of bureaucracy, whereas we could say: "Well, let's now try to provide an economic system that employs the least amount of people possible." But you can only do that if he has an income to fall back on.

So the only way we will ever get to our full measure of proficiency is if we have a place for people to go and that, of course, is where the beginning would come with a true method of distributing the wealth of our society, not in a socialistic way but in the way that we do it under our present corporate system—that is, you and I—if we own shares in a corporation that is going very well, then we don't even have to lift a finger; we just get the income from that corporation.

When a person is born as a U.S. citizen he becomes a member of our national corporation and if that national corporation does well, we should not have any hangups to seeing some economic benefit returned to him; and I think if we could make that psychological breakthrough it would open up a prosperity in this Nation that would be hard to comprehend, and that would not rest upon some social conscience, some moral tugging at our hearts that says, "Now, there is somebody who is poor and starving to death and we feel guilty that he is starving to death."

So I think that that would be the major breakthrough.

And I apologize for not having a statement written out in form for submission, and I apologize for the broad, general philosophical lines

but, Mr. Chairman, I think that many times it is our duty to take the philosophical approach and once we make that breakthrough the technical approach becomes very easy.

The CHAIRMAN. Senator Gravel, you have raised an interesting point. I think you have made a real contribution. I think I would have rather a different answer than you, however.

You raise the problem that we have a bunch of rich drones in this country, not as many as some would say, but that we have a bunch of rich drones who are not working and therefore nobody should have to work; that the poor should be privileged to be drones and live on the working man, too. My reaction to that is to make these rich drones work, too, and if I can find a way of doing it we will equalize this thing by putting them out there doing something just like I would want to make a poor man work. In other words, I personally don't think that we have reached the stage where the machines can do all the work and the human beings can just lie around and take what comes out the spout.

It seems to me that we are still at the point where somebody is going to have to get out and bend his back and work pretty hard if we are going to get by in this country and if the country is going to stay up with others. I am an old share-the-wealth man; I would also favor sharing the burden.

You seem to think the wealth comes to the American corporate state. My impression is that all income being created in this country comes from the hard work of somebody, and I don't see why anybody should share in the fruits of that man's effort if they are not willing to make a contribution themselves.

Senator GRAVEL. I don't disagree with that at all. In fact, I agree with it almost totally. The only difference that I think I draw—I come from a base that may be somewhat different—is that I think the assumption is made that because people will have some amount of money that they won't want to work. I disagree with that. I think most people want to work. The only difference is they want to work at something that is meaningful and worthwhile.

Take my situation; take yourself—and I think your situation more than mine is that you don't have to work. I would imagine that you don't have to work as hard as you do. But you work this hard because you enjoy it. There are many people, and I think the membership of the Senate is a very good example. I think most of the membership of the Senate is wealthy enough they don't have to work if they don't want to as individuals; but yet, who puts out more, who has more aggravations; so, obviously, it is something more than economic incentive that causes people to work.

What makes wealthy people work now, what makes a person who is making \$100,000 a year go out and keep working 16 hours a day to make \$200,000 a year when he can't even take the time to spend \$200,000 a year; it is obviously other senses than just a desire to make the dollar. And there are studies we have today that you can offer people more money for the work they are doing and they want no part of it. The work has got to have a different dimension to it.

So if we free society and create a greater mobility in work you will find people who will be doing more work and working harder at it

now that they have the freedom of choice: and what you do by giving them a base is to give them this freedom of choice because, Senator, you have no way to make those rich drones work, and I don't think—regardless of how long this committee, or this Senate, or this Congress, deliberates on the subject—you will find a way to make the poor guy go to work if he doesn't really want to work, because he will spend his talents and resources to beat the system: and so we only have one choice and that is to try to find a system of volunteerism, and I think that system of volunteerism is already there, that people with dignity, people who have self-respect will go to work because not working is a very boring endeavor.

The CHAIRMAN. Thank you, Senator.

Senator JORDAN. Senator, under your plan, which sounds utopian to me, who would do the unsuitable jobs?

Senator GRAVEL. Like the garbage collectors?

Senator JORDAN. Yes, and working in the sewer?

Senator GRAVEL. No question that this presents a unique problem; but would you believe it that right today there are people who do garbage collection and are proud of being garbage collectors? In fact, how many young people are there today who are of wealthy parents or middle-class parents and have moved away from their wealth and want to get into doing things with their hands? I have always made the comparison when people talk about plumbers—you know, we would be in it up to our ears if we didn't have plumbers and if we didn't have somebody to unplug our toilet. Senator Jordan, you and I would have to do it with our own lilywhite hands.

Senator JORDAN. We wouldn't think it is suitable, you see.

Senator GRAVEL. Well, we may not think it is suitable now, but I think if we recognized how important it truly was, and gave it the dignity commensurate with that importance, and if we didn't have anybody who wanted to do it on a voluntary basis, then we would have to pay the plumber to go do that distasteful job more than he is making now, so we would have some natural adjustments in our society that are very important because I think a person who picks up garbage is a damned important person. If he doesn't do it then I have to do it, and I much prefer doing what I am doing. So we would have to pay more than he is getting in society and this might be an intelligent distribution of our income.

I think it would provide some very interesting aspects. Of course, because it is the unknown, we fear it and we stay away from it, but I can only tell you—we admit these are distasteful jobs now; they are very important jobs and I see no difference from a urologist who does a very important but what is considered a distasteful job on the human body and who gets maybe \$150,000 a year because of his specialty, and a person who goes out and picks up garbage which is also a distasteful job but which is just as fundamentally important to our society.

So I think we need some amount of dislocation that will take place, and if we have to pay him incentives in addition to the citizen's wage, in addition to what might be a more generous type of unemployment compensation or unemployment insurance in order to provide more mobility, then, of course, we will just have to do it.

The CHAIRMAN. Senator, I will make you a fair proposition: Alaska is a big State areawide but there are not too many people up there and if you want to try your program in Alaska it is all right with me. I will vote as far as my vote is concerned to let you experiment with it up there in Alaska and see how it works out. My guess is the place will freeze and never unthaw again but if you want to try it again it would be perfectly all right with me to try it.

Senator GRAVEL. Senator, I would be very happy to take you up on that.

The CHAIRMAN. You understand I only have one vote.

Senator GRAVEL. I think it is a good idea because we are only talking about 335,000 people and it wouldn't cost a great deal to implement up there.

Here is how we would go about it. Since we discovered oil in Alaska, it is obviously going to have some benefit to the residents of Alaska. But who else are the beneficiaries of our oil, assuming we get the pipeline unstuck? Who are the major beneficiaries? All the people of this Nation, yet the leasehold benefit may or may not be, depending upon the beneficence of the situation, may not be to the people of Alaska. But since the total energy is going to solve a problem for the totality of the Nation, then maybe what we ought to say is let's turn around and appropriate x amount of dollars from the treasury, and let's say we will provide an income floor for these people in that State for x period of time and see what happens. Let's see if they get lazier; let's see if the people in the bush who do nothing, have got nothing to do but a subsistence type of life; let's see if we give each person \$2,000 per year income, not as a dole, not as welfare, but as his constitutional right for being a member, of being an American, and let's see if that makes him lazier; let's put it for a 5-year period and then if it does make him lazier and if we do develop an indolent breed of people in Alaska, then I will be here; let's make it only 3 years; let's make it 3 years; I will work with you.

If the experiment extended to 5 years, I think it would probably guarantee my reelection and I would be here with you, and then if it didn't work and made a bad breed of person, I would vote with you—I don't want to corrupt the human being in the society any more than anybody else does; but if under some magic we have discovered that the human being is basically a person who wants to contribute and do something intelligent with his life, then maybe we can then expand it to the rest of the Nation and we would be over into a new era of prosperity and a new type of life for the individual in our society that could be unbelievable.

Call it Utopian, but what is happening today is that we are going to force ourselves into doing a little bit of welfare and then we are going to force ourselves the next year to do a little more, and then the year after a little more, and we are going to get to that same point, but the only thing we are going to do in the process of getting there is that we are going to do it reluctantly and at the same time we are going to put all these people of their basic human integrity because we are going to tell them, "We are giving it to you as a dole, not as a right," and there is the fundamental difference of how it is received and why it is given.

The CHAIRMAN. I suspect you are going to have to import quite a few of the Louisiana Frenchmen to drill some of those wells for you; but that is all right; we are drilling wells all over the world and we will be glad to do that job for you.

Senator Nelson?

Thank you very much.

Senator GRAVEL. Thank you very much, Mr. Chairman.

The CHAIRMAN. Fine. Now, the next witness will be the Honorable Edward I. Koch, a Member of Congress from the State of New York.

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE 17TH CONGRESSIONAL DISTRICT OF THE STATE OF NEW YORK

Mr. KOCH. Senator, just for the record, it is Edward I. Koch.

The CHAIRMAN. It is pronounced both ways; I have seen it; I am sure you have, too.

Mr. KOCH. Yes, sir.

I appreciate, Senator, the opportunity to come before this great committee and I come before you to speak in support of H.R. 8799. What I would like to do is to summarize my remarks, with your permission, and put my formal statement in the record. In addition, I would like to submit for inclusion in the record a copy of H.R. 8799 and the prepared statement on this bill presented to the House Ways and Means Committee by five doctors who have been working with the comprehensive health care projects which are covered under H.R. 8799. These are the children and youth and maternal and infant care projects funded under title V of the Social Security Act. The testimony of these five gentlemen was truly superb and I recommend it to the committee.

The CHAIRMAN. Fine.

Mr. KOCH. I would also like to place in the record a letter from Secretary Elliot Richardson in which he confirms a conversation that he had with me. The Secretary appeared before the Ways and Means Committee on this very subject and indicated a need for the extension of the special projects. He supports a 1-year extension; it is not adequate but it shows at least the attitude of the Nixon administration that they appreciate the value of these programs and the need for them to be continued.

Lastly, I would like to place in the record a booklet prepared in May 1971, providing summaries of each of the 68 children and youth projects. This was prepared at my request for distribution to the Members of the House and Senate.*

I am very pleased that H.R. 8799 has a Senate sponsor, Senator Nelson. In addition 16 other Members of the Senate have co-sponsored the bill. The 68 regional children and youth programs known as C & Y projects, and the maternal and infant care programs known as the MIC projects, were originally created in 1967 under title V. These programs were intended to assist the most impoverished children and the

*This document is entitled "The Nationwide Children and Youth Program—a Comprehensive Health Care Delivery System" dated March 1971.

mothers of impoverished children in this country and they were federally funded. There are about 11 million children who fall into the impoverished category of close to abject poverty. One-half million children are being cared for by these programs that number roughly 120 throughout the country.

My own city of New York has nine such C & Y programs and four MIC projects. The thought at the time that the legislation was enacted was that for a 5-year period these funds would be channeled into these particular institutions—hospitals, primarily—and that at the end of that period the States would come in and assume the cost of their operation. Consequently, the direct Federal funding for these projects runs out on June 30, 1972.

The bill which I have introduced would extend this funding for an additional 5 years. It is a bill which is sponsored by 87 Members of the House of Representatives.

The services that are provided by these projects include hospital services and family planning, dental care, nursing, social service, speech and hearing therapy, nutritional services, psychological services, physical and occupational therapy, health education, and all of the things that go into keeping a child healthy. In addition, they also provide prenatal care for the mother.

The nationwide cost of health care for individuals on an average is \$350, an average for every man, woman, and child in the country; but the cost for care under these projects comes out as of June 30, 1971, at \$129.81 per patient, appreciably below the average for care in this country; and, in spite of inflation, it is estimated that by June of this year the costs will actually be reduced—something that is unheard of in programs—to \$126 per child with an increase in the quality and spectrum of care provided.

One interesting statistic, because it deals directly with life and death, is that in one area of New York City, Morrisania, in the Bronx, the maternity and infant project is responsible for a 50-percent drop in the infant mortality rate of that particular area.

If the bill is not approved and the money goes to the States in the form of bloc grants, many of the existing programs will not be funded. For example, the State of New York would receive \$9 million less than it presently does under title V. And it has been made very clear by the people in the State of New York that I have discussed this with that it would be impossible for the State of New York to pick up the additional costs. I assume that New York's fiscal problems are no less than those of any other State and that other States would also find themselves unable to carry on these particular programs. This would be devastating.

What my bill would do is increase the funding so that the States would receive the increment of funds due in fiscal year 1973, and at the same time money would continue to be available for the special projects.

Continued Federal funding for these special projects has the endorsement, among others, of the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the National Association for Retarded Children.

To conclude, Senator, I would like to read a short paragraph from one of the summaries included in the booklet I referred to earlier. The following remarks are about the Seattle program:

When the children and youth project first came to Seattle, it was difficult to gain community enthusiasm. It may have been because their experience with public programs resulted in large promises and short delivery. Our population now regards the children and youth project as their project, a facility they can count on. It would be disastrous to violate this faith.

Thank you, Senator.

The CHAIRMAN. I thank you.

Senator NELSON. As I understand, the administration position now is that they would favor a 1-year extension?

Mr. KOCH. Yes; that would appear to be the position of Elliot Richardson. He said in a letter to me:

We appreciate your interest in these programs and I trust we can look forward to your support in our efforts to secure favorable congressional action on a 1-year extension of the title V Special Project Grant Authority and on enactment of the National Health Insurance Partnership Act.

Senator NELSON. If only a 1-year extension were granted, do you have any reason to believe that the States would or could assume the responsibility of funding these programs thereafter?

Mr. KOCH. No; I believe that the States will not fully fund these programs. They are simply not in a position to do so. By way of example, just look at what is happening in the State of New York. The Willowbrook State Institution for Retarded Children had its budget cut by \$20 million this year; this cut was only restored after the news media publicized the suffering endured in the institution by children because of the lack of care.

Senator NELSON. It is my understanding that GAO is now reviewing all title V programs, is that correct?

Mr. KOCH. That is correct. In addition an interim report has indicated that these programs are very effective. They have made recommendations with respect to better monitoring of the grantmaking process but basically they have found that these are first-rate programs.

Senator NELSON. Thank you.

The CHAIRMAN. Thank you very much, sir.

Mr. KOCH. Thank you.

(The prepared statement and attachments of Representative Koch follows. Hearing continues on page 2630.)

PREPARED STATEMENT BY EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF NEW YORK

H.R. 8799 TO EXTEND FOR 5 YEARS THE FEDERAL FUNDING FOR THE CHILDREN AND YOUTH AND MATERNAL AND INFANT CARE PROJECTS AUTHORIZED UNDER TITLE V OF THE SOCIAL SECURITY ACT

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to speak to you concerning an extraordinarily successful program which is scheduled to terminate on June 30, 1972 after 5 years of existence—the special project grants under Title V of the Social Security Act. I have introduced legislation to extend the federal funding for these Children and Youth and Maternal and Infant Care projects for an additional five years at a funding level of \$630,000,000. This bill, H.R. 8799, is cosponsored by 86 Members of the House and has been introduced in the Sen-

ate by Senators Gaylord Nelson, Edward Kennedy, and Abraham Ribicoff with 14 other sponsors.

There are at present 68 regional Children and Youth programs with additional satellites and 56 Maternal and Infant Care programs in existence delivering comprehensive health care to $\frac{1}{2}$ million children and youth of lower socioeconomic levels in central cities and rural areas. Although it was the intent of Congress that these existing projects should continue with State support, that now seems highly unlikely given the budgetary strain on all of the states, as for example, New York which has 9 C&Y and 4 MIC projects.

These projects render quality medical care at low cost to mothers and children in low income families within medically deprived communities. Medical services provided include hospital services, family planning, dental care, nursing and social services, speech and hearing therapy, nutritional services, psychological services, physical and occupational therapy, health education, transportation and follow-through on patients.

We all know from experience, and from scientific data, the serious consequences emanating from a lack of medical care during pregnancy and in childhood and adolescence—lead poisoning which undetected leads to brain damage, lack of proper nutritional care causing mental retardation, unwanted children resulting from a lack of birth control guidance and infant deaths and birth defects caused by poor prenatal care. The economic and social as well as medical benefits reaped from quality comprehensive health care are considerable.

The national average health care cost per year per man, woman and child is \$350. The cost for care under these C&Y and MIC projects as of June 30, 1971 was \$129.81 per patient. In spite of inflation, the estimated cost by June 30, 1972 will have *decreased* to \$126. And even with this reduced cost there has been an *increase* in the quality of care. The statistics are impressive. Hospitalization is less for indigent children in C&Y projects than for indigent children not enrolled, and their average hospital stay is shorter. The underprivileged families keep appointments and follow the therapies prescribed more than does the general public. In one area of New York City, the MIC project is responsible for a 50% drop in the infant mortality rate.

H.R. 8799 provides for the funding level for title V to be increased to \$630 million. There are 11 million underprivileged children in this country. The C&Y and MIC projects serve one-half million children. Only one-fifth of indigent obstetric patients are covered by MIC or similar projects. These programs are operating with only modest funding and could serve a much greater population if provided with an increase in funds.

The current authorization for these projects under title V of the 1965 amendments to the Social Security Act terminates June 30, 1972, at which time 90 percent of the funds will be given to the States so that each of the 50 States might have one such project. It was not the intent of Congress that these existing projects be discontinued, but that they be financed by the States. However, in New York State finances being what they are, as is true of most States, it is hardly likely that the State will finance these projects and the result of this will be that the programs will have no funds with which to operate. As important as it is that each of the States have a project, it is just as important that these special projects are not funded directly by the Federal Government, and the money is only received from the formula grants, New York State will receive \$9 million less than it now does from these projects. It is therefore virtually impossible that the State, with its many urban areas, will be able to fully fund even the 13 projects in New York City.

It would be disastrous if these programs were to cease and it would result in a breach of commitment to the community which has looked to these programs for their ongoing care. Since it will be at least 5 to 10 years before there is a sufficient number of group practices able to meet present needs for low-income areas, an extension is required so that these programs will ultimately be able to turn into health maintenance organizations.

Continued federal funding for these special projects has the endorsement among others of the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the National Association for Retarded Children. These projects constitute an existing delivery system of comprehensive health care serving those persons who would be among the

first beneficiaries of a national health insurance program. They must soon receive the assurance from the Congress that continued funding will be forthcoming so that personnel will continue to serve, rather than look elsewhere for new positions fearing the program's termination date.

We must provide medical care for our nation's poor—especially the children of our deprived citizens who suffer in so many ways. The men and women involved in these projects are dedicated persons who have been giving the highest quality of medical care at the lowest cost to these underprivileged mothers, infants, children and adolescents for the past 5 years. In some very unique way they have given more than physical health to their patients. They have eradicated a sense of helplessness for those they serve.

[From the Congressional Record, Nov. 18, 1971]

TESTIMONY IN SUPPORT OF CHILDREN AND YOUTH AND MATERNAL AND INFANT CARE PROJECTS

Mr. KOCH. Mr. Speaker, a panel of five distinguished men appeared before the Ways and Means Committee on Tuesday, November 16, in support of the extension of the special project grants under title V of the Social Security Act. I have introduced legislation to extend the Federal funding for these children and youth and maternal and infant care projects for an additional 5 years at a funding level of \$630 million. This bill, H.R. 8799, is cosponsored by 86 Members of the House and has been introduced in the Senate by Senators GAYLORD NELSON and EDWARD KENNEDY with 15 other sponsors. Their testimony was extraordinarily impressive and I append it for the interest of our colleagues:

"TESTIMONY OF FRED SELIGMAN, M.D., M.P.H.

"My name is Fred Seligman. I reside at 1522 S.W. 81 Avenue, Miami, Florida. I am Director of the Children and Youth Project at the University of Miami School of Medicine and am here today as the Chairman of the Association of Children and Youth Project Directors. I represent the staff of the 68 Children and Youth Programs throughout these United States and the more than 500,000 children and youth who receive comprehensive health services through these programs. I endorse most emphatically the continuation of these programs under Title V of the Social Security Act. Specifically, our Association supports without reservation the bill introduced to the House of Representatives by Congressman Koch of New York (H.R. 8799) and the companion bill introduced to the Senate by Senator Kennedy of Massachusetts and Senator Nelson of Wisconsin (S. 2135).

These programs exist throughout this Nation; in the Virgin Islands, Puerto Rico and Hawaii. There are programs in all corners of the Mainland—Miami, Concord, Los Angeles, and Seattle; Central America—Chicago and Omaha; Rural America—Little Rock, Charlottesville and Helena.

"This Nation is moving in the direction of comprehensive health services to defined segments of the population. Many proposals have been receiving serious legislative concern by many members of Congress. Mr. Chairman, neither our Association nor any member of your Committee would advocate that we move recklessly in establishing a National Health Plan. This task requires considerable thought. Even though our health delivery system is far from perfect, we must resist the temptation to destroy what we already have, only to create something new. We must instead build on those components of our system that have proved their effectiveness and modify only those segments of the health system that require revision. We cannot afford the economic and human costs of abandoning programs that have demonstrated their efficacy. We cannot afford to ignore the critical health problems that daily face this Nation's young.

"For these reasons, Children and Youth Projects as well as a variety of other significant health programs for mothers, infants, children and teen-agers, that are authorized under the current Title V of the Social Security Act, should be continued organizationally intact until June 30, 1977 and expanded to at least the \$500,000,000 level which both bills recommend.

"Because no perfect system has been developed, Children and Youth Projects should continue to demonstrate and develop improved health care delivery patterns to children. Ultimately, Children and Youth Projects will ably phase into an

overall National Health Plan, or, if in the judgment of this Committee, the counsel of our Association be considered wise and visionary, a National Health Plan should ultimately be phased into and expanded upon a merging of the basic triad of Title V of the current Social Security Act, namely Children and Youth Projects, Maternity and Infant Care Projects and Crippled Children's Programs.

"Essential factors of quality health care include comprehensiveness and continuity. Concentration on a defined geographical area provides for efficiency. Neighborhood Health Center Programs are currently the only publicly-supported programs, other than children and youth projects that are explicitly committed to the delivery of comprehensive health services to a specific population group in a well-defined geographical area.

"Children and Youth Projects, both organizationally and philosophically, are distinct from all previously conceived health programs. Children and Youth Projects focus medical and dental care to all children in a family; however, the provision of most ancillary services such as public health nursing, social services, nutrition and health education are usually family-based. Unless there is a specialized focus and concern for children, children frequently do not receive the priority they deserve in family oriented *medical* system. Children and Youth Projects have developed a meaningful model of health delivery with built-in standards accepted by the appropriate professional bodies, that is applicable to children nationwide and upon which can be built family-centered care to children and adults.

"Children and Youth Projects are the only publicly-supported comprehensive health care system that has developed meaningful quality control and evaluate components. While there is a wide variation in average cost per registrant among individual projects, the average cost per registrant was \$162. In calendar year 1969, and is estimated to be \$130, per registrant for the present fiscal year. As compared to the national average health cost of \$350, per man, woman, and child in this nation, these projects are performing economically, particularly considering that these children are drawn from least healthy geographical areas.

"Our program at the University of Miami, like many throughout the country, has demonstrated the efficacy of health care delivery that is based on a preventive rather than an episodic approach. Since initiation, we have decreased our overall cost per patient more than 80% in spite of inflation. Nationwide the projects have increased the frequency of "well-children registrants" by 50%. There have been significant decreases in the number of diagnosed preventable conditions as well as diagnosed correctable defects. Such factors demonstrate the positive impact of these programs through preventive services, correction of defects, and health promotion.

"The value of a preventive approach is seen in respect to hospital admissions. In fiscal year 1969, the hospital admissions in Children and Youth Projects nationwide decreased 36%. The continued need for these programs is demonstrated by the fact that a relatively high percentage of children, particularly in the 5-9 year age group have a low immunization level in the geographic areas served by the Children and Youth Programs. One out of 10 registrants in these Programs fail the vision and hearing screening tests. There have been many published studies documenting these facts relative to Children and Youth Projects.

"Children and Youth Projects are administered by teaching hospitals, official health departments, and Pediatric Departments in medical schools. The Projects are approximately equally divided between these three funding agencies. The impact that these Programs have had on these agencies has been profound, particularly on the voluntary hospitals that I have been involved, and especially on the medical schools. As a medical educator, I can speak to the fact that these Programs have had major impact in exposing medical students and other trainees in the health sciences to an innovative inter-disciplinary health care delivery system, a system that is concerned with maximizing quality and efficiency. New manpower models have been developed in these Programs. Students are learning how they can ultimately interface with the many new ancillary health professionals in the field. An increasing number of these trainees are now choosing careers in community medicine having had meaningful exposure to these Projects.

"These programs have attempted to solve the manpower crisis in health by retraining talented individuals, both professional and non-professional, who have been attracted to these programs. These individuals have thereby gained meaningful experience and expertise in the delivery of comprehensive health services, particularly to children.

"Termination of these projects will mean that these now talented and vibrant individuals will return to the less meaningful professional and ancillary ventures that they came from. Mr. Chairman, our association invites your committee members to visit our programs. There you will sense the enthusiasm of health workers, you will perceive the vitality of concerned people, you will feel the hope and well-being of patients. You will sense an atmosphere of excitement and creativity. You will witness quality care.

"Gentlemen, what this Nation needs is people who care. We speak of a health care crisis in America. Our emphasis has been on 'Health.' Our crisis is not so much in 'Healthy' as in terms of 'Caring,' in terms of developing a cadre of, professionals who truly care for the people they serve.

"Termination of the projects will mean that both professionals and recipients will feel penalized for caring. Already there have been professionals who have left these projects feeling that those in positions of power and authority do not care. For example, four of the Children and Youth Projects in the greater New York City area presently do not have directors because of an uncertain situation.

"Most importantly, termination of these projects mean that the children and youth in our various communities around the country decide again that they have no friends in the establishment and will return to anti-social behavior, juvenile delinquency, poor health habits, sickness and the cycle of poverty."

"TESTIMONY OF VERNON E. WECKWERTH

"My name is Vernon E. Weckwerth. I am a resident of St. Paul, Minnesota in the 4th Congressional District. I am a professor in both the School of Public Health and the Medical School in the Department of Family Practice at the University of Minnesota.

"My testimony today is a distillation of over 5 years of personal involvement in developing an on going management and evaluation of the C & Y program.

"Of the currently registered nearly 500,000 of the nation's poorest children living chiefly in central city slums, about 3 of 5 or 60% are black, about 1/3 or 34% are white with the remaining 5.4% comprised of chiefly American Indians. About 1 of 6 or 17% who are Spanish speaking or of Spanish surname.

"Currently 68 local service projects located in all 10 HEW regions and in 31 states are delivering appropriate services which are citizen acceptable, easily available, readily accessible, of high quality and of low cost.

"The C & Y as a program is national in scope but characterized by an American ideal of being tailor made by and directed to fit the idiosyncrasies of each local area, be it central city, rural or a mixture of population densities. The 68 projects are as diverse in tailor making care delivery to their local areas as their areas and this nation is diverse. Organizational forms include a full spectrum from classical fee for service solo practice private physicians to indigenous community worker quarterbacked coordinated home care delivery teams.

"The C & Y Program has been intentionally cautious about publicity, not wishing to make promises it could not fulfill, not overselling the creative dreams of the hundreds of zealous workers who have too frequently seen demonstration programs satisfy the innovator's needs without benefiting the health of those they purported to serve.

"Critical to C & Y is a rarely occurring if not unique organized flow of services with its data documentation system. This data system was created to produce on-going evidence of the effectiveness of alternative ways to deliver health services. It's data system was created to be the decisionmaking basis for allocating resources, documenting flows of children receiving services, documenting the kind of presenting problems, documenting the frequency and effectiveness of treatment and requiring a written care plan tailored for each child to assure that timely and effective preventive services were received by the child.

"Without question, the current crisis in health care delivery is the crisis of cost, because technically no services are free, someone must pay. Government at all levels must find means by which to obtain from the private sector the dollar resources to pay for the care of government has promised to millions of Americans who do not pay directly for such services.

"Five years ago, one of the first endeavors we undertaken was to assure that the C & Y data system would be structured in such a way that annualized costs per child year of risk could not only be documented but that such data could be

applied to project management on an on-going basis. As part of that development new theoretical efforts were solved and field tested to assure that they would work in the pragmatic day to day service would but also that conceptually they could be used for prediction. Each year for the past 3 years we have projected the annualized costs of services per child year as of the following year. We have always been within \$2 of the actual expenditures once the cost incentive was in and anticipate similar accuracy for next year.

"The dramatic performance in annualized cost reduction in the C & Y is simply summarized this way:

"As of January 1, 1968 at the beginning of such mandatory reporting the annualized cost per child year was \$201 per child. by December 19, 1969 it had fallen to \$162 and by December 31, of 1970 it had fallen to \$140. Our estimate for what the cost should have been as of June 30, 1971 was \$129.81. We have not as yet received final audited expenses from all projects because not all are on a Federal fiscal year but the remaining projects are known by past history to average slightly less than the programs at large. To date that program average annualized cost is slightly less than \$131.

"Our predicted cost for June 30, 1972 is slightly over \$126 per child per year—compared to the popularly cited cost per year per man, woman and child of \$350 in the United States, the health care costs are unrealistically low for such a health deprived population when you consider that that \$131 cost includes medical services, including hospitalization, dental services, nursing services, social services, speech services, hearing services, nutritional services, psychological services and physical and occupational therapy services in addition to health education, transportation by most projects and an array of specially tailored programs to meet problems of the preschooler, the adolescent, the unwed mother and some family planning services.

"Although this management data system was developed over 5 years ago, the essence of its development was to answer questions believed to be those which would be asked and critical to be answered in the early 1970's.

"For example the overall cost measure, annualized cost per child year is the operational term to implement the vague concept of capitation. The organizational forms include substitution and interchange of skills among non-professionals and professionals in teams structured so that less costly workers can do the job in lieu of more costly and usually scarcer workers. Such manpower is critical to most of the current national health services proposals be they acronymed by CHSO, HCC or HMD.

"The array of performance measures which were developed as means of quantifying completeness and continuity of care is the heart of any mechanism for decision making and organizational direction and control or for reorganization of health services in existing alternatives currently proposed.

"For example, each C & Y project receives each quarter a report on its absolute performance by an array of measures such as medical backlog, dental backlog, well child rate, reassessment interval, etc. These measures tell the projects how they are performing, how long it will take to produce healthy children at their current productivity rate for all registrants and how they have allocated resources relative to the major jobs to be done in their project areas. In addition, each project receives a relative ranking to all other reporting projects on each performance measure.

"Currently in vogue is another concept called outcomes of care. The C&L programs and its management information system was created to answer the outcome questions. Too long health programs, health workers and health facilities had believed their existence was a social good and that they were justified by expending time, effort and resources believing they were above accountability as stewards of societal resources. Their beliefs provided data which were no more than wing flapping statistics of head counts, lab tests, visits to clinics and dentists and physicians and days in the hospital. The unit item of service inputs never required nor could they answer whether all those resources did any real good, and only concentrated on accounting that the birds had in fact flapped their wings so many times. No one had questioned whether the bird flew—let alone how high, how far, how long. The C&L program and its tailor made management information system was designed to produce and document the production of healthy children and a management accountability system to assure that children were maintained in that healthy state—within the limits of our own knowledge and skill of the art and science of health care delivery.

"To my knowledge, this is the only health program which is national in organization, which has an on going performance measuring system to reflect an accountability for health maintenance, with appropriate care which is available and accessible and acceptable which is adaptable to any locale in this diverse nation capable of adjusting locally required inputs by a process of providing services which result in accountable outcomes.

"But this glowing tale of documented performance—no special date had to be created for this testimony, no case had to be made with scurrying for evidence of performance or cost benefit analysis—they're all there as an on-going part of this program—has a very bleak other side.

"Our analysis shows that the costs are currently below what they should be. Backlogs are now rising, planned service rates are falling, the growth rate is approaching zero—meaning that many projects have closed their doors to new registrants and many more will within this fiscal year.

"Even though we can with special and very sophisticated Markovian and foregone benefit economic analyses impute the annualized cost per child year for any project, compare it to the actual cost and then determine its economic efficiency the program at large is currently underfunded. Those underfunding effects are now showing operationally. They are deferring required services because of lack of dollar resources.

"All of the program indicators taken in composite shows a jeopardizing of the state of health attained by these children. If the legislation is not extended, let alone if funding is not increased, these half million of America's most health economic deprived children face a return to the devastatingly inadequate, disease oriented crisis emergency scene that characterized the usual and usually only service available to nearly all of them prior to the implementation of these Children and Youth Projects.

"Without question the need is critical, the evidence is in, the facts are available for the reading. The question in a sense becomes—is this just another great idea and a noble demonstration in the graveyard of the health field? Or is it one that has proven itself to become expanded and extended as a prototype for millions more of our children."

"TESTIMONY OF DR. ROBERT E. COOKE CONCERNING TITLE V, SOCIAL SECURITY ACT,
H.R. 1, NOVEMBER 16, 1971

"MR. CHAIRMAN: I am Doctor Robert E. Cooke, Pediatrician-in-Chief, Johns Hopkins Hospital, professor of Pediatrics, Johns Hopkins University School of Medicine, and Chairman of the Scientific Advisory Board of the Joseph P. Kennedy, Jr. Foundation. Our Department at the Johns Hopkins Hospital operates one of the largest children and youth projects, caring for almost 20,000 poor infants, children, adolescents, and young adults of East Baltimore. For over five years the resources of the Children's Medical and Surgical Center of the Johns Hopkins Hospital have been dedicated to the 25% matching support for this program. The Johns Hopkins Medical Institutions have utilized the Comprehensive Child Care Clinic, as it is called, for research supported by private foundations, the Maternal and Child Health Service, and the National Institutes of Health, with participation by the Westinghouse Aerospace Industries. Studies are made on physician efficiency, clinic efficiency, the optimal design of outpatient facilities with respect to utilization of personnel and acceptability by patients.

"RECOMMENDATION

"I am appearing in support of amending H.R. 1 to extend Title V of the existing act as described in sections 508 and 509 with full funding at the 350 million-dollar level with removal of 508B and 509B, as described in the Koch bill which was introduced by Congressmen Burke, Corman, Carey and others. This will continue project grants as 40% of the total, with funds being allocated on a state formula basis of 50% and for research 10.

"JUSTIFICATION

"The Maternal and Infant Care and Children and Youth programs have more than demonstrated their contribution to the health of mothers and children. I will devote my testimony primarily to the need for project grant continuation to permit the concentration of health care in high risk areas, rather than devot-

ing the majority of my testimony to justification of the Maternal and Infant and Children and Youth programs.

"The data is indeed impressive from Maternal and Infant Care centers for the reduction in infant mortality, and for the expansion of family planning services. These are services which cannot be carried out by traditional fee for service activities. The Children and Youth program has brought care to almost one half million needy children. In East Baltimore alone some 20,000 children are under care, with 70,000 visits being made each year, as well as 12,000 community home visits. Over 10,000 tuberculin tests and 3,500 vision screenings are made on an annual basis alone. This project provides the only medical care for some 25,000 children in an area where there is not a single physician caring for children. In one year alone, this project has detected over 200 cases of early tuberculosis, 225 behavioral disorders, 650 cases of asthma, and 200 cases of mental retardation and severe learning disabilities. All of these cases are under treatment. In a study of the effectiveness of the examination program in comparison with a similar control group not under Comprehensive Care, there was 50% greater elective correction of disabling defects—strabismus or squint leading to blindness if not corrected; hernias leading to disability in later life if not repaired early; and serious cosmetic defects which, if not corrected, could lead to serious psychic scars.

"MAINTENANCE OF HEALTH

"A highly sophisticated computer system has been developed in order to flag high risk patients or an uncooperative family needing special social work attention. This follow-up mechanism that we liken to the term "Esso's watchdog service" permits proper supervision of a large number of patients in a way that could not be done by any small group operation: In addition, it provides accountability data which is essential in any adequate assessment of financing.

"COMMUNITY INPUT

"The parents of the children's service provide continued input and review of the program through a fourteen-member Parent Advisory Board. They have assisted in the determination of the kinds and hours of service, made decisions regarding Food Stamps, and assisted in such activities as determining Food Stamp eligibility and housing problems. The parents have also assisted in a major way in combating drug abuse and school dropouts. The training programs for indigent poor have led to excellent employment programs, particularly by means of community health visitors who provide remarkable follow-up in social services.

"A cancer screening program is established with blood and urine specimens assisting in the early detection and treatment of certain kinds of tumors and leukemia. A vigorous lead poisoning screening program has been in existence for several years. In one month alone some 246 children were screened, 88 were discovered with blood lead toxicity, 29 with major toxicity. Of the 29 with major toxicity, 24 have been spared brain damage by early detection, and the other five who were mentally retarded, have been given treatment. Extensive planning for family services has been made available. A training ground for personnel from the community, as well as physician training and recruitment, has been established.

"Traditionally, Johns Hopkins has produced leaders in medical education. Now every medical student at Hopkins has the opportunity to see medical care in the community, to see effective preventive therapy in action. All these activities have been done at the cost of \$142 per registered patient per year which includes outpatient and inpatient dental care, drugs, eyeglasses, appliances, and so forth. Of all the children in the census tract, the cost is approximately \$153 per child per year.

"Our project is not alone in having this excellent record. In Rochester, New York, sharp reductions in expenditures due to extensive economizing have been effected by Comprehensive Child Care. This includes a 38% reduction in expensive and usually unsatisfactory emergency visits.

"NECESSITY FOR PROJECT GRANTS INSTEAD OF TOTAL STATE FORMULA ALLOTMENTS

"If this amendment is not adopted, a decreasing amount of funds will go to states with urban populations. Following a 1935 formula which gave a double weight in funding for high rural birth areas, as a consequence, truly health

depressed urban areas will lose their only source of comprehensive medical care. Fifty-six counties in the United States account for one half of all the yearly excess infant deaths in the United States. These fifty-six counties are mainly large metropolitan centers with large backlogs of other unmet child health needs. Every area needs more for mothers and children but urban ghettos have major health problems.

"INFANT MORTALITY

"Urban areas have far higher rates for infant mortality. For example, the District of Columbia has a mortality rate of 27.3% per 1,000; this is far higher than the national average.

"PREMATURITY

"Prematurity with its serious consequences of mental retardation in a high percentage occurs 2 to 3 times more frequently amongst the urban poor. Births out of wedlock, with a high risk of abnormality, are 10 to 15 times higher in urban areas, as are venereal disease rates in adolescents.

"MEASLES

"Measles occurs $2\frac{1}{2}$ to $4\frac{1}{2}$ times more frequently in low income urban areas. In Los Angeles, Dallas, Houston, and Little Rock, measles occurs earlier far more frequently, with brain damage from encephalitis leading to mental retardation. Inadequate measles immunization occurs in these cities with a much greater chance of spreading to epidemic proportions in crowded city areas.

"TUBERCULOSIS

"Tuberculosis occurs throughout the United States 18 cases per 100,000. In cities such as El Paso, Texas, the rate is 63.9 per 100,000; in Baltimore, Maryland, 54.4; in the District of Columbia, 48.9. Again, in crowded areas, tuberculosis spreads amongst the disadvantaged. Seventy-five percent of these cases could be kept from active disease if early identification and treatment could be carried out.

"ACCIDENTS

"In the National Health Survey of 1968, the accident rate, which is the major killer of youth, was higher by 25% in urban areas. Children had illnesses confining them to bed twice as frequently in the city and considerably more school was lost by the children who needed it most.

"RHEUMATIC FEVER

"Rheumatic fever is three times more common where there is crowding. In the city of Chicago, there are 35 cases of rheumatic fever per 100,000 as compared with Sweden, with 2.3.

"MEDICAID NOT ADEQUATE SUBSTITUTE

"In urban areas, Medicaid cannot substitute for Children and Youth programs. There are no physicians in most areas. The number of physicians giving primary care to children is dropping rapidly. As Doctor Albert Haynes has pointed out in his book *Health Care in the Ghetto*, there has been an extreme loss of physicians: in many center cities the only resource are Children and Youth programs.

"An excellent study from Rochester, New York, published in the *New England Journal of Medicine*, indicates that the pattern of use by low income families has not changed at all as a result of Medicaid; medical services are not obtained except for major illness, in sharp contrast to the patterns of middle income families. Even if there are adequate numbers of physicians, the fee for service approach, conventional private practice approaches, or Medicaid approaches cannot reach the urban ghettos. To reach families who require help most, adequate organization extending into homes and into schools is needed. We have designated such approaches as "hot pursuit," an absolute essential. There must be a large active door-to-door field force and computer capabilities for flagging and identifying important cases.

"EXPLANATION FOR DIFFERENCES

"The major reason for the difference in approaches for staffing patterns which put emphasis on community follow-up results from a remarkable difference in compliance. For example, in community mental health programs amongst the urban poor, 50 to 60% drop out from conventional community mental health centers. Many mental health centers refuse social difficulties. If appointments are not kept, the patient is considered resistive and dropped.

"On the other hand, centers such as those associated with C & Y activities have a vigorous follow-up program, and patients dropping out are considered to be the ones requiring treatment the most. The follow-up of tuberculosis needs active participation from a field force. INH, a very effective preventive measure in children without risk, can be given in a one-month supply but 50% of the children may not return.

"Therefore intensive pursuit is required to develop effective treatment programs. Compliance in the taking of penicillin has been adequately studied. In private practice, 56% of children remain on penicillin for nine days for the treatment of streptococcal throat in order to prevent rheumatic fever. Of the urban poor, 71% have stopped taking penicillin in the treatment of streptococcal throat by the sixth day, and only 18% of clinic patients remain on penicillin through the ninth day, even when the penicillin is supplied free.

"C & Y AS A FOUNDATION FOR CHILD DEVELOPMENT PROGRAMS

"Congress has just passed major Child Development legislation. Many of these activities will use C & Y projects as a major foundation. Parent and Child Centers that are changing the patterns of development of poor young infants, as well as their parents, have frequently grown out of C & Y projects.

"Title IV of the Elementary and Secondary Education Act has four of its eight projects through the Cooperative Research Act of the Office of Education, which are intimately associated with C & Y projects for health and nutrition services in Topeka, Kansas; New York City; Dayton, Ohio; and Galveston, Texas. Several of the new Advocacy Centers in Parent and Child Centers will depend upon C & Y projects for total health care.

"DURATION OF EXTENSION

"The administration has recommended a one-year continuation of the Special Project Grant component of Title V. Such a one-year extension can only be interpreted by the staff and those supporting C & Y projects as a terminal year. Less than a five-year extension will be interpreted as a lack of confidence and support by Congress with further deterioration of the program's activities.

"A five-year extension will permit an incorporation of these activities in the prepayment plans of National Health Insurance programs if they come about, with very significant cost reduction features that have proven to be acceptable and efficient in operation.

"These projects, according to a published paper of the Secretary of Health, Education, and Welfare, have been identified as excellent foundations for new Health Maintenance Organizations. It is absolutely essential that approval from Congress be expedited. Delay of the decision to next year will lead to severe morale problems and loss of critical staffs built up over the past five years.

"SUMMARY

"In over 30 years of medical activity, I believe these projects have accomplished more for the health of mothers and infants than any other federal activity. Instead of defending the continued existence of these projects, we would be encouraging their expansion with greater coverage in the care of needy mothers and children by effective health care programs, rather than simply patch-up procedures. The amendment which we support does not add to the tax burden and actually is one of the most effective means by which costly later disabilities, mental and physical, can be significantly reduced.

"In conclusion, I should like to express my appreciation for the opportunity to appear before this Committee. The leadership of this Committee has traditionally provided wise direction and support for health and welfare programs for children throughout this nation."

"TESTIMONY BY EDWIN F. DAILY, M.D., BEFORE THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES

“(Charts mentioned not printed in RECORD.)

“I am here today in my capacity as the Director of the Maternity, Infant Care-Family Planning Projects of the New York City Department of Health to explain the necessity of continued Federal support of the MIC Project in New York City and similar Projects in 50 cities throughout the United States.

“H.R. 11484, introduced on October 28, 1971 by Congressman Edward Koch, if enacted, will assure continuation of these urgently needed health services for mothers and children.

“New York City has one of the greatest concentrations of low-income families in this country, with more than one-million people receiving public assistance in 1971. As in 1963, they continue to strain the resources of this city, as I believe they do in many other large cities. Before the MIC grants to New York City, there was serious overcrowding of the maternity services in the 15 adequately staffed, tax-supported city hospitals. These hospitals were two or three bus fares away from many families who had no place else to go for maternity care in 1963, so many mothers often got little or no prenatal care.

“In 1963, 40% of the city's residents giving birth were medically indigent; in 1970 this had increased to 50%. In 1963, the incidence of prematurity among general service patients was three times that of the private patients receiving adequate prenatal care and the infant mortality rate of these low or no-income patients was twice as high as that of private patients.

“The New York City MIC program started in 1964 with two maternity clinics in district health centers and has grown each year until now it is operating in 11 Health Department centers in those ghetto areas of the City where the poorest families live. (See may.) The large stars represent clinics providing both maternity and family planning services; the smaller stars where family planning services alone are provided.

“In 1970, 13,000 maternity patients received care in these 11 centers. In 22 Health Department centers family planning services were provided to 35,000 patients. (The graphs attached to my testimony show the growth of the MIC program since 1964.) Medical care is provided by skilled obstetricians or certified nurse-midwives from the staffs of 10 voluntary and 3 municipal hospitals affiliated with the MIC Project. The women are delivered in these hospitals.

“The MIC patients receive total maternity care during pregnancy, at delivery, and postpartum. In addition to obstetricians and certified nurse-midwives, the clinics are staffed with public health nurses, social workers, nutritionists, dentists and the ancillary personnel needed—all under the direction of specialists in the field of maternal and child health. The clinics are operated on the appointment system—broken appointments are promptly followed up. Humane and dignified patient-doctor, patient-nurse relationships are maintained. Consultation or hospitalization for complications is readily available in the affiliated hospitals. Specialized teenage clinic sessions are available to meet the many difficult problems of the young unmarried mothers.

“The MIC program has made great strides in reducing infant mortality in New York City, as evidenced by the following figures. In 1964, when MIC started, the infant mortality rate was 27 per 1000 live births; in 1970, it was 21.6—a decrease of 24%. However, the Mott Haven Health District of the Bronx, where MIC placed two of its largest services, the infant mortality rate has dropped over 50% during these six years! In the adjoining Morrisania Health District, also with MIC services, the rate dropped 30%! Another adjoining Health District—Tremont—without MIC services had an increase in infant mortality during the same six year period.

“The perinatal mortality rate (late fetal and early infant deaths) is lower for MIC delivered women than for all private and nonprivate births in New York City. Considering that the MIC patients live in the poorest areas of the city, many of whom are known to have had inadequate housing and food for most of their lives, this reduction in infant and prenatal mortality rates must be attributed in no small part to the work of the MIC program.

“We talk with every prenatal patient about the importance of preventing unwanted pregnancies by using a birth control method after the baby is born. Before they leave the hospital, our peer-level family planning counselors get them started on a birth control regime of their choosing. Studies have shown that 40% of the children born to low-income families were not wanted by the parents. In

New York City alone, this would mean 25,000 unwanted children are born each year to low-income families. Unwanted children often create serious social and economic problems within the family, especially if there are other children. That is why, at the same time we try to provide good maternity care under MIC, we make every effort to minimize the occurrence of unwanted pregnancies in future years. I am confident these efforts are related to the declining birthrate in New York City. Furthermore, the cost of raising these children educating them and providing health and social services is often a staggering cost to the community. If the MIC and In-Hospital Family Planning program, described in the reprint attached to my testimony, prevents even 10,000 unwanted pregnancies in a year among the 60,000 women to whom we provide post-partum and post-abortion family planning service each year, it will result in a savings of at least \$10 million in tax funds per year—which is three times as much as the annual MIC grants to New York City.

"Mayor John Lindsay, in a recent communication to Secretary Elliott Richardson, stated that 'It appears most unlikely that local funds could be made available to support these lifesaving health programs if the Federal MIC funds are not available after June 30, 1972.'

"The New York City Health and Hospitals Corporation announced in October that, because they have been unable to operate within the budget approved for the Corporation, they plan to reduce through attrition, all staff (except physicians and nurses) in the municipal hospitals by 12%. Inasmuch as the municipal hospitals are already inadequately staffed, this can only have a highly deleterious effect on patient care.

"To abandon the MIC program and return the MIC patients to the overcrowded clinics of inadequately staffed and under-financed municipal hospitals would scatter to the winds all of the advancement made in the delivery of maternity care during the past seven years. Once again, these patients, many of whom face special health hazards, would be subjected to long hours of waiting in the overcrowded clinics of most of the municipal hospitals. There would be a means test and charges which would result in many patients receiving no care.

"The quality of maternity care now available through the MIC board-qualified obstetricians and nurse-midwives, social workers, nutritionists and dentists, and other staff in the MIC clinics would not be available to this population without MIC. Gone would be the warm patient-doctor and patient-nurse relationship never before known to most of the patients before MIC. The MIC clinics convenient to the homes of the patients, now serve one-fifth of all general service patients in the city. 30% of MIC patients are on welfare and 70% are from what have been designated as 'working poor' families. Without MIC or other Federal funding, the MIC maternity clinics in New York City will have to close. Last week, I talked with Dr. Byron Hawks, the MIC director in Little Rock, Arkansas, who told me that if MIC funds are not continued, the low-income women in that city would have to return to 'granny midwives' for maternity care.

"The United States is one of the wealthiest nations in the world. There are funds to support armies, to aid other nations, to subsidize the farmers and yes, even to subsidize the railroads and aircraft industry. Surely funds can be found to finance essential health services for the nation's low-income women. I know your committee is giving consideration to various proposals for financing nationwide health services. I hope that whatever legislation is enacted will assure the financing of specialized high quality maternity and infant care services wherever needed. Since a new nationwide health program cannot be operative for several years, discontinuing MIC would leave an enormous void between 1972 and until a national health program is in full operation.

"I can assure you that tens of thousands of women living in ghetto areas of the cities who have or will benefit from MIC services, will be grateful and relieved if the Congress approves continuation of these desperately needed health services for mothers and their children."

"NEW YORK CITY'S IN-HOSPITAL FAMILY PLANNING PROGRAM

"(By Edwin F. Daily, M.D., Aileen R. Sirey, and Lucille S. Goodlet)

"In May 1970 over 2,800 medically indigent maternity or post-abortion patients in 23 New York City municipal and voluntary hospitals received family planning counseling—and in seven out of 10 cases were initiated on a contraceptive method—before hospital discharge. The counseling is provided on the maternity

wards by 51 family planning counselors specially trained and employed by the Maternity and Infant Care-Family Planning Project (MIC-FP) of the New York City Department of Health. The counselors are themselves mothers; some had been on welfare; all live in the vicinities of the hospitals they serve.

"The In-Hospital Family Planning Program was begun on an experimental basis in July 1969 with maternity patients in three hospitals. The program is expected to reach 4,000 low-income women each month by the end of 1970 and will be extended from the obstetrics and gynecology departments at least to the out-patient departments of the municipal hospitals. Two more municipal, eight voluntary and four state mental hospitals will be added to the program, with counselors assigned to medical, surgical, psychiatric and other services. It is hoped that eventually in-hospital family planning counseling and services can be offered to all of the 140,000 general service patients of child-bearing age who are discharged each year from New York City municipal and voluntary hospitals.

"The major objectives of the new in-hospital program are:

"To offer family planning information and services to large numbers of women of child-bearing age at a time when they are most receptive.

"To create a community system to provide such patient education and service involving the cooperation of the Department of Health and the OB/GYN departments (and eventually other departments) of New York City's municipal and voluntary hospitals,

"To develop an effective method to select and train community women so as to foster a maximum of commitment and initiative, and provide them with sufficient skill and knowledge so that they can work with a minimum of supervision.

"To operate this program at a per patient cost far less than the cost of traditional outreach programs, and

"To augment scarce manpower resources by employing community women and preparing them as family planning counselors, thus channeling much of the program's funding back into the communities that are served.

"BACKGROUND

"The MIC-FP project basically provides prenatal care for 12,000 new patients each year in 14 neighborhood centers and hospitals, and family planning services for some 16,000 new patients a year in 28 neighborhood centers.

"Early in 1968 the Department of Health, Education and Welfare invited the New York City Department of Health to submit a plan and budget for an expanded family planning program. The MIC-FP director met with chiefs of obstetrics and gynecology in 12 hospitals then participating in the MIC-FP program to seek their advice. These physicians emphasized the importance of getting family planning help to patients as soon as possible after delivery, since this was the period when motivation to accept contraception was highest. They pointed out that numbers of patients were becoming pregnant between their hospital discharge and post partum visit, and that at least 60 percent of patients never returned for a post partum examination. They also suggested that it would be useful to introduce birth control to postabortal, medical, surgical and psychiatric patients of child-bearing age. Despite the tremendous need for introduction of such services, these physicians said, family planning was a low priority item for busy hospital residents, nurses and social workers. A new type of health worker was needed, they said, recruited from the patients' own communities, and specially trained to educate their neighbors about family planning.

"Initiation of contraceptive counseling and services immediately after parturition had been tried with some success at Cook County Hospital in Chicago and Grady Memorial Hospital in Atlanta. In neither case, however, was the counseling performed by peer group women drawn from the patients' own neighborhoods. (In Chicago, volunteers—predominantly white and middle class—counseled a patient group which was poor and mostly black; in Atlanta nurses provided the counseling.) The In-Hospital Family Planning Program was developed (and endorsed by the OB/GYN chiefs of the 12 hospitals and other key health and family planning leaders in the city) so that family planning counselors would be recruited from the hospital communities, trained by MIC-FP project staff and placed in hospitals which wished to initiate family planning for their patients. The plan and budget (\$137,000 for the first 12 months; it is now

up to \$500,000 a year) was approved by the Department of Health, Education and Welfare (DHEW) Children's Bureau* in March 1969. By July:

"A core staff of family planning coordinators had been hired in MIC-FP's Division of Community Education to organize recruitment, screening, training and supervision of the family planning counselors. The coordinators are college graduates, some with experience in teaching or the behavioral sciences, and all with a deep interest in the development of family planning services.

"Site visits were made to Grady and Cook County Hospitals to observe the in-hospital family planning programs developed there.

"A seven-week training course for family planning counselors was developed, and an initial group of six women was recruited and training.

"DEVELOPING THE PROGRAM IN NEW YORK CITY

"In October 1969 the program was extended to the OB/GYN departments of the nine voluntary and six municipal hospitals then currently participating in MIC-FP projects. Subsequently, agreements to participate in the in-hospital program were signed with a total of 13 municipal and 10 voluntary hospitals with two more municipal, eight more voluntary and four state mental hospitals expected to join the program by the end of 1970.

"(The in-hospital agreement is a formal document signed by the OB/GYN chief of the hospital and the MIC-FP director. The OB/GYN department of the hospital agrees:

"To take charge of the family planning program in the hospital.

"To offer all generally accepted methods of family planning (including IUD, pills, tubal ligation and rhythm),

"To offer family planning services at least to all maternity and abortion patients, before discharge unless there is a medical contraindication.

"To provide family planning services and materials to patients without charge.

"To acquaint all doctors, nurses and nurses' aides working with women of childbearing age in the hospital with the importance of family planning to the health of mother and of future children and to the economy of the family.

"To inform all prenatal patients attending the hospital's OPD service of the importance of family planning and provide appropriate family planning literature,

"To appoint a physician thoroughly familiar with all methods of family planning and the indications and contraindications for various methods, and give him responsibility for medical supervision of the in-hospital and out-patient family planning program.

"To appoint a nurse-midwife or a nurse interested and fully informed about family planning to assume day-by-day supervision of the family planning counselors,

"To instruct all nurses on daytime duty on floors covered by the family planning program about dispensing of pills when this is the method prescribed, and to instruct residents serving these floors about medical approval or disapproval of the methods selected and about insertion of IUDs,

"That patients started on a family planning regimen (other than tubal ligation), will be given a written appointment for their first post discharge family planning visit in a hospital or health department clinic most convenient for the patient; a copy of the appointment slip will be sent to the clinic selected, and a copy sent to the MIC-FP director, and

"That missed return appointments to the family planning clinic will be followed up by one or two telephone calls or letters requesting that another appointment be made.

"The MIC-FP director agrees:

"To employ and train family planning counselors and assign them to participating hospitals on a full- or part-time basis (depending on the average number of discharges per day of patients),

"If the OB/GYN department already has family planning counselors, to reimburse the department for the number of hours each month spent on the in-hospital family planning program,

*The Childrens Bureau initially directed DHEW's family planning projects grant program, now under the jurisdiction of the National Center for Family Planning Services of the Health Services and Mental Health Administration.

"To pay the OB/GYN department to help defray its added costs: \$4.00 for each inpatient initiated on a family planning regime of pills or diaphragm before discharge; \$6.00 for each patient with an IUD inserted before discharge: \$25.00 for each in-hospital tubal ligation before discharge.

"The per capita reimbursement to the OB/GYN departments averages about \$7.25 per patient who is initiated on a medically prescribed method.

"The role of the counselor is clearly defined: Her duties consist of solely providing family planning information to patients, filling out statistical forms required for reimbursement and seeing to it that a post partum and family planning appointment is arranged for every patient who is initiated on a contraceptive method.

"After the agreement is signed, the MIC-FP's Director of Community Education and Training and one of the family planning coordinators begin a series of informal meetings with key hospital staff to reinforce their awareness of program objectives and their understanding of the role of the family planning counselor, as well as to assist professionals in working through complementary role activities with these new peer counselors. Experience has shown that in some hospitals the program is met hesitantly at first.

"Typical questions raised are: 'Who *are* these people?' 'What kind of training do they have?' 'How much supervision will they need?' And though never articulated, some staff members' attitudes clearly showed that they felt professionally threatened.

"MIC-FP's coordinator is responsible at each hospital for establishing an atmosphere of cooperation, and assuring staff involved that the family planning counselors will not add to their already heavy responsibilities.

"RECRUITMENT OF FAMILY PLANNING COUNSELORS

"Community women are recruited as trainees for the in-hospital program through discussions with such grass-roots agencies as community corporations, Puerto Rican Manpower Development, Planned Parenthood's Community Action Department, the Puerto Rican Guidance Center and the New York State Employment Center. In some cases advertisements are placed in community newspapers.

"No educational qualifications were established for the position of family planning counselor in order fully to utilize the untapped human resources in the community. At the same time some kind of criteria were needed to evaluate candidates so that the program would not be faced with continual turnover of staff into whose training a great deal of money, time and effort has been expended. A screening process was devised whereby groups of seven to 10 applicants are seen by a staff interviewer and observer. The interviewer describes the program, briefly outlines the responsibilities of the family planning counselor and stimulates group discussion on such subjects as local community problems or the applicants' feelings about family planning. Through this group screening process candidates are sought who can discuss "sensitive" topics on a mature level, show tolerance of the opinions of others and can articulate their own thoughts and feelings. Candidates are expected to show an interest in hospital work and need to be able to read and write sufficiently well to handle the statistical forms.

"The interviewer and observer meet after each screening session to discuss each applicant's responses and to select candidates for training. Applicants about whom there is some question are asked back for an individual interview with a different staff member. About one out of five applicants are accepted for training.

"Successful candidates are started in the training program immediately. The salary during the seven weeks of training is \$2.50 per hour, \$3.00 an hour when assigned to a hospital and \$3.50 an hour after six months. The salary is supplemented with full health insurance (a benefit available for the first time to many of these women and their families).

"TRAINING

"The training program was developed to provide factual knowledge about family planning, reliable techniques to impart knowledge to patients and an understanding of hospitals and hospital procedures.

"A number of questions about the training program soon became salient:

"What did the trainees already know?

"What would happen to the counselors' ability to relate on a 'peer level' after intensive training?

"If the counselors' education was formal and didactic, wouldn't they relate in the same formal and didactic way to the patients?"

"It was decided that a laboratory training experience tailored to each group's particular needs was required to encourage individual initiative.

"The first day of training begins under the direction of a psychologist-consultant.

"Both professional staff and trainees engage, on a first-name basis, in activities designed to break down the barriers to communication. On succeeding days the group discusses the role the counselor will play in the hospital. Out of the questions trainees raise about the job, topics for investigation are formulated about family planning, reproduction, human sexuality and hospitals. In the atmosphere of mutual respect engendered by this laboratory approach to training, life experiences are exchanged without self-consciousness, trainees giving "tell-it-like-it-is" reasons for human behavior, and the coordinators contributing factual knowledge from their own professional experience. Methods and media include lectures, panel discussions, role-playing and problem-solving sessions. On-the-job training experiences at a municipal and voluntary hospital are provided as part of the counselors' seven-week training course.

"HOSPITAL EXPERIENCES

"At least two family planning counselors are assigned for each hospital to talk about contraception with the patients and where possible, with their husbands. When the patient is interested in a method, the counselor informs a resident, who prescribes a method after examining the patient. The counselor visits the patient again to explain the details of the method chosen. She completes the statistical form for reimbursement and makes a post partum-family planning appointment for four to six weeks after the patient is discharged. About one in five patients have received their prenatal care at an MIC clinic. These patients are referred to an MIC-FP center in their neighborhood for their post partum and family planning care. Others may come back to the hospital or are referred to a more convenient neighborhood facility. Appointment and counseling records follow the patients from hospital to clinic where a referral has been made. (Clinics have begun to participate in a joint record system whereby each patient is identified by a unique numbering system derived from her maiden name, date and place of birth.) The counselors have found almost all patients eager to discuss family planning (most have *never* discussed family planning before with a health worker) and to have their questions answered in their own language.* All the hospitals participating started the counselors on the OB/GYN service with instructions to interview all post partum and all post-abortion patients before discharge. Each counselor is able to reach about five to 10 patients each day. At the present time there are 51 counselors in 23 hospitals; in the month of May they interviewed more than 2,800 patients.

"The problems that have arisen are as interesting and as varied as the 23 hospitals with which we are working. Three OB/GYN chiefs objected to the immediate post-partum use of steroids, but were willing to prescribe other methods; patients wishing the pill in the three hospitals were given a supply of foam to use until their post partum appointment, and were informed that they would be started on the pill three to four weeks later. In a few hospitals, at the beginning, residents balked at cooperating with the program; they saw family planning as a low-priority item in their busy schedules and feared that the counselors would make extra work for them. Other hospitals did not have residents who were able to insert an IUD. One hospital pharmacy refused to dispense pills to patients before discharge; while in another the chief of obstetrics had to be persuaded not to ask the counselors to give pills to patients. A few floor nurses feared that the counselors would overlap some of their functions or "be in the way." This fear was quickly allayed as the nurses observed how well informed the counselors were, and how much the patients liked and trusted them. Soon nurses and other hospital personnel began to come and listen in on the patient-counselor discussions to become more closely acquainted with patient problems related to family planning. One hospital administrator questioned whether it was legal for a health department employee to work in the hospital. (He was reassured that liability for

*Of the first 3,500 patients counseled in the program, half were Puerto Rican and only 200 were mainland white. Well over half of the counselors are bilingual in English and Spanish.

the counselor was assumed by the health department.) In several hospitals, operating room time is at a premium, and tubal ligations, though requested by patients and their husbands and approved by the hospital committee, cannot be performed before discharge. Such patients are asked to return when the hospital is less crowded and are provided with an interim method of contraception.

"STATISTICS

"Table 1 shows that between July 1, 1969 and May 1, 1970 family planning counselors interviewed 17,706 patients in 21 New York City hospitals. At least nine out of 10 patients interviewed indicated that they wished to begin contraception before discharge; 68 percent of this group received contraception while still in the hospital. Of those initiated on contraception in-hospital, 51 percent received pills, 19 percent IUD's, 10 percent tubal ligations and 20 percent foam and other methods. Some of the hospitals are much more committed and better staffed to implement patient choices about in-hospital initiation of contraception than others.

Thus in 13 hospitals where there is strong endorsement by the OB/GYN chief, and a resident assigned full-time to the program, more than 80 percent of patients interested were provided with contraception before discharge. In one hospital, of 1,247 patients interviewed, 1,226 indicated that they wanted to start family planning and 1,212 were initiated on a method of contraception before hospital discharge. As the program becomes more smoothly integrated into the routine of more hospitals, it is expected that the number of contraceptive initiations will be closer to 100 percent of the patients interested. This trend can be seen in Table 1: Whereas 67 percent of patients counseled in the first six months received contraception in-hospital, 76 percent of patients counseled in April 1970 were so initiated. The number is not likely actually to reach 100 percent of patients, however, since the policy of the various hospitals about initiation of certain methods (namely orals and IUDs) immediately after parturition varies, as does their capability to perform certain procedures (e.g., tubal ligations) while the patient is in the hospital. Fifty-seven percent of the patients initiated on a method of contraception declared they wanted no more children. Sixty percent of the women accepting a method had two or fewer children. Fifty-six percent were married; forty-four percent were single, separated or divorced.

"TABLE 1.—NUMBER OF NEW YORK CITY WOMEN WHO HAVE RECEIVED IN-HOSPITAL FAMILY PLANNING COUNSELING, REQUESTED AND RECEIVED CONTRACEPTION IN PARTICIPATING HOSPITALS,¹ JULY 1, 1969 TO MAY 1, 1970

Month	Number of patients counseled	Number requesting contraception	Number initiated on contraception before discharge	Number of participating hospitals
July 1969.....	712	677	454	10
August 1969.....	804	746	586	11
September 1969.....	1,000	894	698	11
October 1969.....	1,047	951	703	18
November 1969.....	1,891	1,790	1,032	18
December 1969.....	2,325	2,161	1,344	19
1969 (6 month) total.....	7,779	7,219	4,817	19
January 1970.....	2,382	2,136	1,306	19
February 1970.....	2,130	1,836	1,231	19
March 1970.....	2,667	2,356	1,668	21
April 1970.....	2,743	2,441	1,848	21
1970 total for 18 hospitals ²	7,674	7,062	5,500	18
1970 total for 3 hospitals ³	2,280	1,707	553	3
1970 (4 month) total.....	9,927	8,769	6,053	21
Grand total.....	17,706	15,988	10,870	21

¹ Participating hospitals are: Bellevue, Beth Israel, Bronx Lebanon, Brooklyn Jewish, Brooklyn-Cumberland, Broodkale, Flower-Fifth Avenue, Greenpoint, Kings County, Fordham, Lincoln, Long Island College, Methodist, Metropolitan, Morrisania, Roosevelt, St. Luke's, Sydenham, Coney Island, Harlem, Jacobi. (On June 1 the program was extended to Brooklyn Women's and DeJafeld Hospitals.)

² Hospitals in which all methods are prescribed prior to discharge.

³ Hospitals in which the pill is not prescribed in-hospital."

"FOLLOW-UP

"Patients' visit behavior after hospital discharge is monitored through a simple visit information form. Clinics to which the patients are referred receive five visit forms numbered for the first and each subsequent patient visit, and are asked to return the forms each time an appointment is kept. These visit forms are filled out almost entirely by the family planning counselor, and stamped self-addressed envelopes are included to minimize demands on busy clinics. Since compliance is voluntary, however, response from the clinics is uneven (though it has shown considerable improvement in recent months as clinic clerks have become more used to the procedure). To check out the rate of return for the post partum clinic visit, the statistical form was matched with clinic medical records for an MIC-FP clinic and its affiliated hospital for one month. The study showed that the kept appointment rate for the hospital clinic was 71 percent and for the MIC-FP patients 89 percent. This compares to a kept appointment rate of 40 percent for hospitals and about 80 percent for MIC-FP clinics prior to initiation of the In-Hospital Family Planning Program.

"Using the established reporting system, non-MIC patients from three hospitals complying with the follow-up protocol were studied. The results add to the impression that pre-discharge initiation on a method helps to increase post partum return. An overall post partum return rate was calculated for each hospital. The samples were then dichotomized into 'initiated' and 'non-initiated' subsamples. The overall return rates for the three hospitals were: 40 percent, 50 percent and 63 percent respectively. Corresponding return rates for the 'initiated' subsamples were: 63 percent, 83 percent and 81 percent. For each hospital, the sample constituted patients counseled during one full month. Return was defined as a kept post partum appointment reported within three months of discharge. Of these initiated patients who returned for the post partum appointment, 97 percent, 87 percent and 84 percent, respectively, reported that they were active contraceptors in the interim period between hospital discharge and post partum return.

"Patient retention, however, is a general family planning in big cities; an average of 50 percent of family planning patients have dropped out of New York City clinic programs in the course of each year, mostly, it is believed, because of frequent changes of address. It is expected that increased in-hospital contraception and the resultant improved post partum returns should improve overall retention. Traditional follow-up and outreach programs involving home-visits to patients does not appear to be practical in New York City because of the high degree of mobility and the practice, on the part of some maternity patients, of falsifying address to gain admittance to a particular desired hospital. One New York City study found that the cost of locating each delinquent patient, utilizing trained community women as home visitors, averaged \$361.00 per patient who returned to the clinic.¹ Home visits, therefore, are only made where there is a specific medical indication, such as a positive Pap smear.

"Because of the known difficulties of following very mobile low-income families, a three-month pilot study of a new follow-up method was begun June 1 of this year in one voluntary and one municipal hospital chosen to provide a patient population representative of the city as a whole in terms of ethnicity, age, parity, economic status and contraceptive method chosen. Women who have begun a method of family planning in the hospital are being advised by the family planning counselors that a routine part of the service is a monitoring of her satisfaction with her chosen method after hospital discharge. Patients are told that other counselors will be available by telephone from 9 a.m. to 8 p.m. every day (except Saturday and Sunday) to answer questions. Patients are asked to telephone MIC-FP on dates suggested in advance for the first three months after hospital discharge.*

"Each woman is asked to make the first call immediately after discharge to introduce herself to her 'woman's health counselor.' (The patient is given the

¹R. K. Westheimer, 'Maternal Care, Family Planning, and the Paraprofessional Community Health Worker,' paper delivered at the Ninth Annual Meeting of the American Public Health Association, Philadelphia, November 1969.

*It was considered that follow-up would prove successful only if patients were invited to participate in a personally meaningful service available from the moment they left the hospital. It was decided, therefore, that counseling would be provided by a rotating staff of the very counselors the patients had come to know as informed peers; counseling would be immediately available, all day and through the evening hours, in a single, central location where there is supporting professional personnel.

name of the health counselor by the family planning counselor.) All patients are asked to call every week until one week after the post-partum visit. From that time the frequency of calls is varied systematically by patient groups (weekly, biweekly and monthly) to study which is most effective.

"Patients are invited to call any time they have a question or problem, and are urged particularly to contact the counselor *before* discontinuing a method for any reason, or if they plan to move.

"All groups are provided with a calendar that displays the telephone call schedule, the name of the woman's health counselor assigned to the patient and the MIC-FP direct line telephone number she is to call. The calls are without cost to the patient. A special telephone installation immediately processes *all* incoming patient calls toll-free. For example, a patient calling from a public telephone has her dime returned by the operator before the call is actually placed. And the patient is spared the potential embarrassment of telling the operator she wants to place a collect call; the special letter and digit combination of the telephone number itself advises the operator of the fact that the cost of the call will be borne by MIC-FP.

"At least 50 percent of all patients counseled in the hospitals report having a phone in their own homes. The toll-free call system should encourage the use of public telephones among the balance of the women. The calls, whether placed from a home or a public phone, are a simple means to provide continuity.

"The telephone calls are received at the MIC-FP central office by neighborhood women who have received the same training as the in-hospital family planning counselors as well as additional training in understanding telephone interaction. A complete record for every patient is kept adjacent to the telephone for immediate reference each time a call is received. With each new contact the record is updated. Calls from patients with problems or questions that require expert response are referred to appropriate MIC-FP professional staff.

"A control group has been drawn from a similar patient population. Efforts will be made to contact this group three months after the counseling experience. In the interim these patients will not have had any deliberate reinforcement of their initial counseling other than that which would have occurred at the post-discharge clinic visits; opportunity for reinforcement of method use in the clinics is equally available to all groups. Substantive information secured from the study groups will be asked of the control patients at the time of delayed contact. Retention in the two groups will be compared.

"COST OF THE PROGRAM

"Unit cost for the first 11 months of the in-hospital program was calculated on the basis of the costs of professional, paraprofessional and clerical personnel, educational materials, operational supplies and reimbursements to hospital OB/GYN departments.

"The cost for each patient initiated on a family planning method before hospital discharge was \$15.28, of which \$7.25 (approximately 50 percent) represents a fixed per capita return to the participating OB/GYN departments. The cost of the family planning counseling service currently is \$6.23.*

"The cost to the Department of Health and the Department of Hospitals for continuing family planning visits for these patients must also be considered. This is about \$40-50 per year per woman remaining on family planning. Thus, the total cost of initiating and maintaining a new patient on family planning is about \$55-65 the first year.

"In-hospital initiation thus appears to be a comparatively efficient and low cost means of bringing family planning to a post-delivery patient.

"It is expected that the in-hospital program may double in 1971 the number of new patients coming to tax-supported clinics in New York City as compared to the number of new patients admitted in 1969. The eventual additional cost of initiating and maintaining our target of 50,000 patients on family planning each year, will be in the neighborhood of \$3 million. This should be compared to current costs for care of unwanted children.

*"The proportion of the cost that represents reimbursement to hospitals is unaffected by cost-effectiveness considerations because it is fixed. The unit cost per patient interview, independent of initiation outcome, is the only aspect of cost that is sensitive to efficiency in the delivery of services.

"Applying the recent findings of Bumpass and Westoff¹ on unwanted pregnancies to New York City, there are at least 40,000 unwanted births occurring each year. The medical, hospital and related costs alone for these unwanted births are approximately \$60 million per year. The subsequent increased welfare costs, infant care costs, care of mentally retarded, etc. for these unwanted children create a far greater fiscal burden for the community each year.

"CONCLUSIONS

"Withing 11 months the in-hospital program encompasses 23 hospitals and has counseled 18,000 patients. Currently, over 2,800 women a month are receiving counseling and more than seven out of 10 receive contraception before discharge from the hospital. The program is being expanded this year to the OPD department of all municipal hospitals and into the medicine, surgery and psychiatry departments in one voluntary hospital to determine whether our first priority should be to expand the program in participating hospitals or to extend services into OB/GYN departments of additional hospitals.

"Hospital OB/GYN departments and the Department of Health have demonstrated that they can cooperatively develop an effective and efficient program for initiating a family planning regime before women are discharged. We believe this program can be duplicated by other MIC-FP programs and by health departments working with hospital OB/GYN departments in many other cities. The end results, as measured by prevention of unwanted births, will not be known for several years, and then only if new methods of follow-up of highly mobile urban families are productive.

"The selection and education of peer level counselors is considered by the authors as the most important element in assuring success of such a program. Their proven usefulness in this program is evidence that peer level counseling can be used far more widely in family planning. For example, could not such family planning workers be valuable in such settings as junior and senior high schools where the community and teachers wish to initiate family planning discussions with teen-age boys and girls?"

"STATEMENT OF DR. ROGER B. BOST ON THE CHILDREN AND YOUTH PROJECT BEFORE THE HOUSE OF REPRESENTATIVES, COMMITTEE ON WAYS AND MEANS

"INTRODUCTION

"I welcome and appreciate this opportunity to talk with the Committee about a health care program, the continuance of which is vital to the State of Arkansas, individually, and the United States collectively—"The Children and Youth Project". I am Roger B. Bost, Director, Department of Social and Rehabilitative Services, State of Arkansas. I am also professor of Pediatrics at the University of Arkansas Medical Center, Fellow of the American Academy of Pediatrics and former Director of the Children and Youth Project in Little Rock, Arkansas.

"GENERAL

"The Little Rock Children and Youth (C&Y) Comprehensive Health Project 658 was funded 1 July 1968, initiating services 1 October 1968. Throughout its tenure, the Little Rock C&Y Project's primary thrust has been devoted to organizing and structuring a health care delivery system which would reflect the objectives envisioned by the 89th Congress in the 1965 Amendments to the Social Security Act. The prime objective has been to develop a system which would provide easily accessible, continuous comprehensive health care services for children of low-income families through promotion of health including, "early case finding, preventive health services, diagnosis, treatment, correction of defects, and follow-up utilizing a multidisciplinary approach." One index relative to the effectiveness of these efforts is manifested by the \$267,944 expended during Fiscal Year 1971 to support out-patient and in-patient services for our C&Y population.

¹L. Bumpass and C. F. Westoff, "The "Perfect Contraceptive" Population: Extent and Implications of Unwanted Fertility in the U.S.," *Science* (in press).

It is significant that these payments were authorized only after all other community resources had been petitioned, without success, to pay these charges. In Little Rock, and across America, the C&Y projects frequently represent the medically indigent's sole resource in obtaining health care for his family.

"GEOGRAPHIC AREA

"The Little Rock C&Y geographical area encompasses 25 census tracts in Pulaski County, Arkansas. Examination of the census tracts would reveal that they encompass the eastern portion of Little Rock and the southern and eastern portions of its twin city North Little Rock and three distinct areas outside the city limits. The principal criterion utilized in designing the project area was predicated upon the large number of low income families depicted on the 1960 census tracts. The total population for this area is approximately 118,103. There are approximately 25,521 family units of which 7,911 or 31% have a total income of less than \$3,000 per year. There are approximately 35,248 children between 0-16 years of which an estimated 18,000 are eligible for treatment with project funds. Approximately 10,700 of these children are registered in the Little Rock C&Y Project. Children and youth costs per registrant per year have averaged approximately \$60. Delivery of services along the entire health care continuum for this sum represents, by all accounts, a very favorable cost/benefit ratio.

"HEALTH CARE DELIVERS SYSTEM

"The children and youth enabling legislature encouraged creation of new health care delivery systems. We have therefore endeavored to produce an operational model which would be both sensitive and responsive to the health needs of the population within our particular geographical area. From these efforts there has evolved a network of care centers with varying levels of capability. The University of Arkansas Medical Center, with its concentration of expertise, provides the base for specialty consultations and sophisticated diagnostic and therapeutic support for complex medical problems. Arkansas Children's Hospital, an 85 bed non-profit voluntary hospital, affiliated with the University of Arkansas Medical Center, represents the next level of care in our delivery system. Approximately 50% of our episodic and acute problems are solved in this very excellent institution which is easily accessible to a large segment of our project population.

"The next level of care consists of satellite neighborhood health clinics. Each satellite clinic is routinely staffed by children and Youth Project pediatricians, nurses, social service workers, nutritionists, a laboratory technician and clerks. A psychologist, physical therapist, audiologist and speech therapist are available to augment the clinic staff upon request. Care provided in the satellite clinics consists of episodic care, preventive health services, and assessments. The first satellite clinic was established at College Station, a community located in southeastern Pulaski County where it is isolated both geographically and socio-economically. Its problems reflect poverty that is extreme even relative to other portions of the Children and Youth Project area.

"The College Station clinic is located in a community-controlled building which is leased by the community Economic Opportunity Agency, (EOA). Cooperative arrangements exist between the C&Y Project, EOA, The Community School, Head Start and Follow-Through programs. The second satellite clinic was established at Kramer School, Seventh and Sherman Streets, Little Rock, Arkansas. It was found to be impractical and was discontinued. The third satellite clinic was established in the North Little Rock Health Department in North Little Rock. Public transportation available to the clinic makes this an ideal location for all registrants in North Little Rock. Patients presenting conditions beyond the capability of the satellite clinic are referred to either Arkansas Children's Hospital or the University of Arkansas Medical Center. Within the parameters of this particular health care delivery system we are able to move each child toward the best state of health that the art and science of health care can now create.

"COMMUNITY HEALTH SERVICES COORDINATION

"Cognizant that interagency cooperation can potentiate the value of a multidisciplinary approach to comprehensive health care, the Little Rock C&Y Project personnel have been eager to cooperate, rather than compete, with other

modalities of health care in the community. There have been both intensive and extensive efforts by the C&Y staff to assure existing community services were utilized in developing treatment plans for their registrants. Some of these agencies include: Little Rock, North Little Rock, Pulaski County and Arkansas State Health Departments; School Health Programs; Volunteer Health Agencies; EOA Clinics; USDA and Commodity Distribution: Crippled Children's Division; Maternity and Infant Program; Police Courts; Child Welfare Agency, etc. Similarly, there has been extensive interactions with community groups to assure the consumer point of view was given proper consideration.

"SUMMARY

"The Little Rock Children and Youth Project has provided health care services that were badly needed, genuinely wanted, effective and not exorbitantly expensive. Additionally, the wisdom of the 89th Congress in establishing Children and Youth Projects as a vehicle for providing comprehensive health care to low-income families while concomitantly encouraging innovative approaches in developing effective health care delivery systems has been well documented. The Little Rock Children and Youth Project has been an effective instrument in translating from legislation to reality the principle that good health care is a right rather than a privilege. I strongly urge that the Children and Youth enabling legislation be extended."

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., December 6, 1971.

HON. EDWARD I. KOCH,
House of Representatives,
Washington, D.C.

DEAR MR. KOCH: Many thanks for your letter of October 21, regarding the programs authorized under Title V of the Social Security Act. Please forgive the delay in responding.

It was a pleasure to see you at the hearing before the Ways and Means Committee and I enjoyed our discussion on the contributions Title V projects have made to providing health care to mothers and children. As you know, it is our plan to assure that current recipients of these health services, as well as others not now able to obtain such services, have the ability to purchase health care through programs developed under the National Health Insurance Partnership Act.

However, until such time as our health financing proposals have been acted upon by the Congress and are in operation, we believe it important to support the health care resources developed under Title V. Therefore, we are recommending a one-year extension of the Title V Special Project Authority to June 30, 1973 in order to bring it into phase with the other health special project statutory authorities of the Department, such as the Partnership for Health, Family Planning and Community Mental Health Center Programs. We intend to develop on a coordinated basis mechanisms which will insure a smooth transition from those special project grant authorities now used to support the delivery of health services to the comprehensive health insurance financing programs we have submitted.

We appreciate your interest in these programs and I trust we can look forward to your support in our efforts to secure favorable Congressional action on a one-year extension of the Title V Special Project Grant Authority and on enactment of the National Health Insurance Partnership Act.

With best regards,

Sincerely,

ELLIOT L. RICHARDSON.
Secretary.

[H.R. 8799, 92d Cong., first sess.]

A BILL To amend title V of the Social Security Act to extend for 5 years (until June 30, 1977) the period within which certain special project grants may be made thereunder

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled. That section 501 of the Social Security Act is amended by striking out "\$350,000,000" and inserting in lieu thereof "\$630,000,000."

SEC. 2. (a) Paragraph (1) of section 502 of the Social Security Act is amended by striking out "each of the next 3 fiscal years" and inserting in lieu thereof "each of the next 8 fiscal years."

(b) Paragraph (2) of section 502 of such Act is amended by striking out "June 30, 1973" and inserting in lieu thereof "June 30, 1978."

SEC. 3. (a) Section 505(a) (8) of the Social Security Act is amended by striking out "July 1, 1972" and inserting in lieu thereof "July 1, 1977."

(b) Section 505(a) (9) of such Act is amended by striking out "July 1, 1972" and inserting in lieu thereof "July 1, 1977."

(c) Section 505(a) (10) of such Act is amended by striking out "July 1, 1972" and inserting in lieu thereof "July 1, 1977."

(d) Section 508(a) (3) of such Act is amended by striking out the comma after "services" and inserting in lieu thereof "during fiscal years ending on or before June 30, 1973."

(e) Section 508(b) of such Act is amended by striking out "June 30, 1972" and inserting in lieu thereof "June 30, 1977."

(f) Section 509(b) of such Act is amended by striking out "June 30, 1972" and inserting in lieu thereof "June 30, 1977."

(g) Section 510(b) of such Act is amended by striking out "June 30, 1972" and inserting in lieu thereof "June 30, 1977."

The CHAIRMAN. Our next witness will be Dr. Leonard W. Cronkhite, Jr., general director of the Children's Hospital Center in Boston, speaking for the Association of American Medical Colleges. He is also chairman-elect of the Council of Teaching Hospitals Administrative Board.

STATEMENT OF LEONARD W. CRONKHITE, JR., M.D., CHAIRMAN-ELECT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES' COUNCIL OF TEACHING HOSPITALS, ACCOMPANIED BY JOHN M. DANIELSON, DIRECTOR, DEPARTMENT OF HEALTH SERVICES AND TEACHING HOSPITALS, AAMC

Dr. CRONKHITE. I am Dr. Leonard W. Cronkhite, Jr., executive vice president of the Children's Hospital Medical Center and chairman-elect of the Association of American Medical Colleges' Council of Teaching Hospitals. With me today is John M. Danielson, director of the Department of Health Services and Teaching Hospitals of the AAMC.

The association represents all of the Nation's 109 medical schools, 405 of our leading teaching hospitals, and 47 academic societies from both the basic science and clinical disciplines. Because of this broad representation, I believe we can speak effectively for the typical academic medical center, which includes the medical school, the faculty, and the teaching hospitals.

At the outset it should be made clear that as a representative of our Nation's teaching hospitals the AAMC does not claim that its members are entitled to any special benefits under H.R. 1. It does claim, however, that teaching hospitals should not be subjected to any penalty or discrimination because of the method whereby profession care is provided to patients in a teaching setting which may differ and does in fact differ from methods of operations utilized in other settings.

In reviewing H.R. 1, there are two sections specifically which are of particular concern. These are sections 227 and 232, to which I would

like to address myself this morning. Both of these sections in different but strongly related ways will have a significant, if not profound, impact on the quality and quantity of health services provided to the Nation's medically underserved people as well as the financial stability of our teaching hospitals and medical centers.

The first section of concern, section 227, relates to the matter of payment under medicare for services of physicians rendered at a teaching hospital. The legislation being considered by the committee would change the basis of reimbursement for supervisory and teaching physicians from a fee-for-service basis, part B, to a cost-reimbursement basis, part A, except where (1) the medicare patients are bona fide private patients as defined in regulations; or, (2) during the 2-year period ending December 31, 1967, and each year thereafter all the hospital's patients were regularly billed by the hospitals for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges, including applicable deductibles and coinsurance, has been regularly collected in full or in substantial part from at least 50 percent of all inpatients.

Let us be sure we understand that basically the second portion of the above section is directed toward the payment of cost, as opposed to fee for service, in the teaching setting for those patients who are poor.

There is continued reference in the bill to the methods of payment for professional services to the poor prior to medicare as the standard for determining the future value of professional care. We believe the value of this professional service should be applicable regardless of the setting in which it is rendered and to whom it is rendered.

In the same sense, one segment of our population should not receive professional care at a lower value simply because the service was rendered differently prior to medicare or because a charge was not billed and collected for the service. This provision reinforces the continuance of a two-class system of care, a system which we understood titles XVIII and XIX were originally designed to eliminate and provide accessibility for the law's beneficiaries to a single class of care.

I should quickly relate this matter to cost in section 232.

We read in disbelief the provision of section 232 that is contradictory to the payment of cost in these large teaching hospitals. Under present law, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare.

The legislation before the committee would allow States to develop their own methods and standards for reimbursement; thus, medicaid reimbursement would in no case exceed medicare payments, but could be less. As a result, we observe in one section of the bill that we will be paid cost, and yet in another section are informed that for medicaid patients payments may be paid that are less than cost. Again, we are discussing the quality and quantity of services provided to the poor since this section clearly affects the institution's ability to provide adequate facilities, equipment, and manpower.

Therefore, I believe that the legislation before you virtually guarantees underfinancing the facilities and manpower to provide services to the poor. There is constant reference in discussions of medicaid to relieving the fiscal crises of the States. If the Congress sees fit to relieve

the fiscal crises of the States under the medicaid program, we believe this should be done by provisions we understand are already under consideration by this committee, whereby the financing of medical care for the poor is largely a Federal responsibility, not, as the present bill before you would indicate, a responsibility of the already undermanned and often obsolete facilities of the public hospitals.

To further expand the nature of this problem, we should examine the results of precipitous cutbacks in the medicaid programs in New York and Missouri as well as other States. These cutbacks have forced institutions to diminish the scope and intensity of health services provided to medicaid recipients in order to reduce expenditures to meet lower levels of medicaid reimbursement.

Having been forced into such action, we are now having this result utilized as the justification for giving lower medicaid reimbursement the force of law. Such legislation will assure the impossibility of upgrading the quality and quantity of services to the poor, to which the Nation's teaching hospitals are committed.

The history of the involvement of medical school faculties working in teaching hospitals clearly demonstrates that we have been and continue to be responsible for the organization and provision of health services to the poor. This was not solely a matter of opportunity to acquire an appropriate patient universe within which graduate and undergraduate medical students could be exposed to patient care: it was, without question, an obligation to care for patients no one else would recognize as their responsibility. We have done it in the past and we will continue to do it.

Many voluntary hospitals cannot afford such patients, particularly with price-freeze constraints placed upon them, nor can they be forced to care for patients, except in emergency, who are underfinanced to the extent that it could threaten the financial viability of the institution. Who is left to take responsibility for these patients? The teaching hospitals, since they include the majority of our major public hospitals, as well as other teaching institutions, who for geographic and other reasons find themselves uniquely committed to the care of indigent patients.

We find it disconcerting, unfair, and unrealistic to bear a burden of financial insolvency and once again give the poor inadequate facilities and understaffed professional services.

Before concluding, I would once again like to return for a moment to section 227.

It should be drawn to your attention that these restrictions that place the emphasis upon how professional services were provided prior to December 31, 1967, disallow the development of institutionally based group practices which could and would attract young physicians into the areas of underserved populations. Considering what we believe to be the intent of Congress: that is, to encourage new and better ways to deliver care to the medically underserved, this section has the opposite effect; in fact, there is no incentive to make constructive changes.

Institutions, as well as individuals, clearly require incentives in order to make progressive changes.

In summary, our concern is over the lockstep nature of both of the provisions of the bill as I have outlined their implications. In related

fashion, these sections prevent the possibility of providing more accessible care of higher quality to the Nation's medically indigent, and at the same time threaten the financial solvency of the only institutions to which the poor can attain access to the delivery of health services.

I respectfully submit these views for the committee's consideration and I thank you for the opportunity to convey our concerns to you this morning.

The CHAIRMAN. Doctor, you have some good points in your presentation.

I do want to ask about one matter.

We have found difficulty in getting doctors to work as general practitioners. I know in my State when we try to look after the poor, we find we can't obtain enough general practitioners. The young men are being encouraged to go into specialized fields. There also is a problem of getting someone to practice away from the urban areas; they like to go to the big hospitals in the urban areas.

Why couldn't we work out some way, with all the young people anxious to get into these medical schools, to place a condition on some of those we admit that they would go where we need them, even if we only require them to do it for 3 years, or something like that?

Dr. CRONKHITE. I think this problem of maldistribution by geography and maldistribution by specialty or nonspecialty is one of very major concern for us as well as for you.

Various countries have tried experiments to solve the problem of maldistribution by subsidizing the education of young physicians of service in an underserved area.

In European countries where this has been tried, sir, apparently the contract does not have the force of law, by and large, it is lived up to, and we certainly have had similar experiences in our own Armed Forces where the Armed Forces subsidize the young men's education in return for a certain number of years for armed services duty, and that certainly is a practice I would support.

So far as turning out general practitioners is concerned, I think the anachronism today is medical schools and their teaching hospitals are, indeed, turning out large numbers of specialists and very few general practitioners. There are a number of reasons for this, not the least of which is several decades of an academic life style which makes for good life, a specialty life rather than a general practitioner.

Here, however, I think that the free marketplace will eventually begin to work because, in fact, the population is asking for a family physician, whereas the medical schools are turning out specialists without regard to need.

When everybody, for example, under national health insurance has the same buying power, then there is no question that the free market would operate and people would drift back into general practice because that is where they could work, and if we overproduced too many neurosurgeons, some of them are going to be out of work.

The CHAIRMAN. That is fine, but it seems to me as though you are talking about a solution you think in the long run will solve the problem, but in the long run we are all dead. It seems to me in view of what we are investing in building medical schools and in helping with med-

ical problems, particularly at the State schools, where the State builds them at State expense and the State pays the faculty, we have a right to ask something in return for what we are giving.

Dr. CRONKHITE. I would agree with you 100 percent.

Again, I think the subsidy does work if you can take a young man who otherwise would not be able to go to medical school and pay for his medical education providing he would perform the function of a general practitioner for an x number of years.

The CHAIRMAN. I think you have the right to go beyond that: you have 10 men who want to be admitted to school and you could say to them, "Well, now, we can't take but five of them. We will take the five who will agree to go where they are needed for 5 years or something of that sort and thereafter they can practice where they want to practice."

Yes?

Mr. DANIELSON. Senator Long, I think that one of the things that will help to resolve this maldistribution is if our academic medical centers take a responsibility for the coverage and backup of these underserved areas.

We have peculiarly, it seems to me, the tool to get our young men to go in there, and to help them to practice if we back them up. I think the backup is critical since you cannot parachute young men or force young men to go into dangerous areas or areas that are unattractive to practice: but I do believe if you offered them positions as assistant professors in the department of medicine in the local medical school or area medical school and back them up in those areas and gave them upward mobility and ways to get out and put another young man in there. I really believe the key to a great deal of maldistribution is centered around whether or not our academic medical centers will assume responsibility for underserved areas.

Now, if they are going to do that, one of their major problems, Senator Long, is that they are not financially in a position to do that. It is difficult for them to take on responsibilities outside in a community which are full, total, comprehensive responsibilities for care, if they are underfinanced doing what they are presently doing. I think there has to be some consideration of helping them to meet their financial needs if they are going to participate and back up these young men.

I believe young men will go to the underserved areas but only if they are backed up and they have some opportunity for continuing education, some backup of the specialty work. To parachute them in there and abandon them is unrealistic. But I believe the academic medical centers hold the key to that: they need to be financed and helped.

The CHAIRMAN. Any further questions, gentlemen?

Senator JORDAN. Only this: how would that operate, Doctor, in a State that has no medical college whatever?

Mr. DANIELSON. Pardon, sir?

Senator JORDAN. How would it operate in a State that has no medical college whatever?

Dr. CRONKHITE. This is a problem. The national figures would indicate that about 40 percent of the graduates of the 109 medical schools say to practice in the State in which they are educated, which does make it a problem for these States that have no medical school. The

concept of a regional school is not a new one, where a number of States, each of which might be poor and unable to have a medical college of its own, could get together and form a regional school.

I think that the location where one gets his education is indeed a major factor but it isn't the only one.

Mr. DANIELSON. There are, Senator, some schools that are crossing State lines; for example, the University of Washington at Seattle is taking on some responsibility for those States that do not have medical schools and have some primary care centers supporting general practitioners in terms of continuing education, members of the faculty going there to teach and so on. I think this is happening but it seems to me that the academic medical center must take that kind of responsibility and not abandon underserved areas.

Senator Jordan. Thank you.

Senator NELSON. May I ask a question? Isn't it true that to most people who are outside the medical profession, of course, we are not turning out many general practitioners anymore but are turning out specialists in internal medicine? Is that not correct?

Dr. CRONKHITE. That is right.

Senator NELSON. We are going to turn out fewer and fewer practitioners by the educational standards of a previous era, and more and more internists who are, in fact, general practitioners; is that not correct?

Dr. CRONKHITE. One of the difficulties today, sir, is that internists who are being turned out in large numbers, by and large do not take care of children nor has he been trained to take care of children. He also isn't terribly happy in taking care of minor problems or trauma where a few stitches would do the trick. He is a little more pure than the kind of man I am talking about who is a family physician and does pediatrics and minor surgery. This is the kind of man we are talking about that is broadly needed.

Senator NELSON. We are not educating that particular individual for that particular purpose in the way of educating pediatricians and internists?

Dr. CRONKHITE. I think we are trying to educate them but the fact of the matter is they are not choosing that life.

Senator NELSON. Now, the other question frequently raised here and in the Health Subcommittee of the Labor and Welfare Committee is the question of practitioners serving in a small town.

In the pre-World War II era the physician was severely limited by the transportation problems involved in serving an area of 8, 15 miles surrounding the local community—because he went by buggy and cutter in the winter and over some pretty broken up roads during most of the summer. So transportation limited the area he could serve. But the idea we are really going to somehow or other persuade doctors who really want to practice to get out there, really isn't worth talking about, is it?

However, if you were talking about area service, it is easier to travel 50 miles today than it was to travel 7 miles 40 years ago; so if you are talking about regional clinic type situations where several of the disciplines could be involved and a doctor could service an area in a radius of 50, 60 miles, this seems to me to be much more

practical for several reasons: (1) The medicine is better; (2) the service is available because it is a short distance to travel; and (3) you can attract people who want to practice good medicine into a clinical situation whereas you are not going to attract good physicians to a practice in an isolated area where there are no supportive medical services. Isn't that correct?

Dr. CRONKHITE. I think you are right, Mr. Nelson. I think the rural model we have been dreaming about in the past few years will cover a great area in which there may be practitioners in a town of 600 doing a primary business of sorting out and the physician base in another area riding circuit on occasion and having a base and, as Mr. Danielson says, some sort of backup; then it would be 150 or 200 miles away because we are trying to create a model in the rural area.

If somebody asked me if a physician would wish to settle permanently in a town of 1,000 people in northern Maine, I would say no; it is not even reasonable to contemplate.

The CHAIRMAN. Thank you very much, gentlemen, for a very interesting presentation.

The next witness will be Dr. Emerson Walden, president of the National Medical Association, accompanied by Dr. John Chissell, Dr. Erman Edgecomb, Dr. John A. Kenney, Jr., and Mr. Loy Kirkpatrick.

STATEMENT OF EMERSON WALDEN, M.D., PRESIDENT, NATIONAL MEDICAL ASSOCIATION, ACCOMPANIED BY DRS. JOHN CHISSELL, ERMAN EDGECOMB, AND JOHN A. KENNEY, JR.; AND LOY KIRKPATRICK, COUNSEL

Dr. WALDEN. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, we appreciate the honor of being able to represent the National Medical Association. I am Dr. Emerson Walden of Baltimore, Md., and I am the president of the National Medical Association, an organization which represents 6,000 black physicians in this Nation.

We have submitted a summary of our testimony on this H.R. 1 to your aides which we have modified somewhat.

Being doctors, we like to take sometimes a second and third look at important things so we have taken the liberty of modifying our summary statement and the modifications of those have been submitted to your aides and I will point them out as I go along with my statement.

I ask respectfully that this modified summary and our supportive data be made a part of the permanent record of this hearing.

With me, to my left, is Dr. John E. Kenney, Jr., who is chairman of our medical legislative committee and a member of the board of trustees of the National Medical Association.

With him is Dr. John T. Chissell, a general practitioner of Baltimore, Md., who is a member of our medical legislative committee and I think he will be able to give you some of the answers to the questions that you directed to the previous speaker; and Mr. Loy Kirkpatrick who is our counsel to the committee.

Our first modification will be what we call page 1A.

The National Medical Association has always acted in a manner to promote the good life for all Americans. This, of course, includes good health and quality health care. In this context, in 1962 we became the first body of organized physicians to support medicare. Although we felt very proud of our position at a time when professionals generally were opposed to governmental subsidy of health care needs of various segments of our population, we know that the job is far from being done. Consequently, we reluctantly supported the passage of medicaid.

We felt then, as we do now, that tacked-on programs, especially when ill-conceived, fail in their mission when we offer second-class programs to any segment of our population.

The relative success between medicare and medicaid is like the difference between night and day and suggests the health gap which must be bridged between all segments of our population.

Happily, we see trends in that direction. The degree to which this gap has been closed and its rate of acceleration has in many ways been related to increased Federal activity in the field of health. Not only has there been more and more health legislation but also implementation of major health care programs has moved forward in an unprecedented fashion. The relative success of each program has been far from uniform in quality, both within a given category and between categories. What is of major significance is that several key public policies have been developed regarding the provision of health to citizens in the United States.

One of the most lucid and yet simplest stated concepts marking the shift in policy was stated by the then surgeon general, William H. Stewart, speaking to the National Health Advisory Council of 1966 in reference to the passage of the Partnership for Health Act:

Every person should have ready access to high quality personal health services and every person should live in an environment which is safe from preventable hazard and is conducive to healthful and productive living. The first thrust is to remove the inequities and inadequacies in access to and quality of personal health care. The second is to assure maximum protection against diseases and hazards in the environment.

The aforementioned policy declaration, the implementation of certain programs and the rising tenor of public debate have been affected to some degree in most aspects of society, our people, our institutions, our units of government and our wealth.

In recognition of current policies and projected needs, it is clear that some direction is necessary in order to focus more precisely on matching needs with well-defined solutions.

Hoping to provide this august committee with some thoughts on how that direction can be achieved with regard to H.R. 1, and now we can go to page 2, paragraph 2, I would like to summarize the principal points of our testimony and then elaborate upon them in the remaining minutes of time allotted to us for our statement.

First, while we can understand and are to some degree sympathetic with the principal objectives of H.R. 1, we feel that many of its provisions are objectionable from the point of view of the poor and the disadvantaged, whose interest we feel we must speak for and protect since so many black people fall into this category. Thus, we are most opposed to the cutbacks in the medicaid program which various provision of H.R. 1 would effect.

Second, while we are not unalterably opposed to the principle of health maintenance organizations, HMO's, we have grave doubts as to their probable ownership—few minority groups would be able to find the capital to participate, as proposed regulations now stand—and also we have grave doubts as to the level of care HMO's would provide to the poor under the provisions of H.R. 1 as we understand them.

Third, we do note with favor certain features of H.R. 1 which liberalize medicare provisions.

Now please allow me to expand on these principal points with some specifics.

We find objectionable those provisions of H.R. 1 which, for economy's sake, would permit states to reduce the scope of their medicaid programs, even though they would expand medicare coverage.

Specifically, we are opposed to section 230 which would repeal section 1903(e) of the Social Security Act, 42 U.S.C. 1396(e), which forbids the Department of HEW to continue medical assistance grants to States unless a State made a satisfactory showing that it would, by July 1, 1977, provide all possible medical services to all those who would be eligible therefor under relaxed eligibility requirements.

We are opposed to section 231 whose intent is to permit States from 1 year to another to eliminate optional services such as drugs, dental care, and eyeglasses, though retaining certain mandated service; and to section 207 which would reduce payment by the Federal Government to the States by one-third for inpatient hospital and skilled nursing-home care in excess of 60 days per fiscal year.

We do not like section 209(d) which would, among other things, exempt States from any requirement to provide medicaid coverage either to poor persons who would be covered under the Family Assistance Plan of proposed title XXI of the Social Security Act, or to the blind, aged, or disabled who would be covered under proposed title XX of the Social Security Act, and section 208(a) which would require the medical needs—persons sufficiently well off to cover food, clothing, and shelter without public assistance but with insufficient income to pay medical bills—to bear enrollment fees, share costs, and bear deductible expenses.

We feel these sections of H.R. 1 all burden the poor. All of these appear to us to deprive the poor of access to a better supply which is now available to the more affluent members of the population.

With regard to HMO's, we have two principal concerns:

In view of sections 207 and 226 of H.R. 1, one single HMO serving both medicaid and medicare eligibles would be limited in the amount of care to be offered medicaid members but practically unlimited in the care which could be given to medicare members. We find this patently objectionable. We believe a unitary standard of care is imperative for both medicaid and medicare beneficiaries and certainly very definitely so in the instance when care is to be rendered by one single HMO.

Sections 207 and 226 should be amended to allow HMO's operating under section 207, State contracts, and section 226, Federal contracts, the opportunity to provide the most comprehensive health care possible to all its members and subscribers. Such an amendment to these two sections will necessarily require authorization of additional ap-

propriations from the General Treasury to cover the difference in costs for medicaid-level services and the actual cost to HMO's for rendering truly comprehensive care to all its members, the same type of care provided by medicare.

Our reservation regarding HMO financing is this: H.R. 1 provides no financial assistance for the formation of HMO's. Although S. 1182 does provide such assistance, aid is limited to 90 percent of construction costs. We feel that financial assistance in the form of 100 percent construction loan guarantees and grants for initial operating costs must be provided by H.R. 1 if some of the very groups whom this legislation should reach—innercity black groups—are to have the means of owning and operating the health facilities H.R. 1 comprehends in its section 226. As we read H.R. 1 as it now stands, no such financial aid is contemplated. We feel this is a serious defect and that it should be remedied.

We also have some objections, Mr. Chairman and members of the committee, about the status of private practice as described in H.R. 1.

The definition of HMO has amongst its basic purposes the elimination of fees for services and physician compensation.

Section 226 of H.R. 1 defines an HMO as an organization which delivers care by physicians who are employees or partners. While some provision is made for recognition of medical doctors as partners of an HMO, effect being given to financial realities, it is far more likely that physicians would be employees. While section 226 will allow HMO's to contract for the services of outside physicians, it would only permit such outside physicians to be reimbursed on a lump-sum basis. Section 226 thus envisions contracts between HMO's and the various specialists in the area served whereby the specialist would be required to care for all HMO patients referred for an overall fixed fee.

If the black physician does not join an HMO or organize an HMO, then one may be set up in their neighborhood, causing their patients to be siphoned off.

Since HMO's would, under H.R. 1, be all-embracing, rare would it be in the country at large and certainly in the innercity for any physician to receive any payment other than fixed fees. So powerful would the HMO negotiating position be that many physicians would probably agree to just accept employee status with an HMO.

That ends our testimony at this point, Mr. Chairman, and we will entertain any questions you might have.

The CHAIRMAN. Thank you very much.

Senator CURTIS. I am interested in what you say about the HMO's. As it is presented in H.R. 1, do you regard it as a proposal to provide cheaper medical care or better medical care?

Dr. WALDEN. As we understand the legislation, sir, we regard it as a concept to be developed into one which would provide better care. This is as we understand it.

As it is presently, as the legislation reads, it would provide worse care and we would like to see it modified.

Senator CURTIS. I say H.R. 1 was written?

Dr. WALDEN. Yes.

Senator CURTIS. Does it appear to you that the objective may be to provide cheaper care there than the emphasis on better care?

Dr. WALDEN. Yes.

Senator CURTIS. There is language in the House report that would indicate that that was probably what they had in mind.

Now, when an HMO operates outside of a governmental program, the participants, the members, or the patients, they can drop out if they are not satisfied, can't they?

Dr. WALDEN. Yes.

Senator CURTIS. But if an HMO takes over the operation of medicaid why they have got pretty much a captive group there; isn't that right?

Dr. WALDEN. That is true.

Senator CURTIS. I think the matter has some very serious questions—the HMO as it appears in H.R. 1.

Dr. WALDEN. I think we agree, sir, that it is a concept that we would like to see developed and we would like to put into the development of it for its improvement insofar as reaching the people that we are concerned about.

Senator CURTIS. Yes; and there is some language in the House report that would imply that where physicians' services are paid for on a fee basis for services rendered, there is an abuse by supplying more services than the patient needs.

Do you think that is a serious charge—or that it represents any broad scale abuses in that field?

Dr. WALDEN. Not at all. It is a charge but it is unfounded, particularly in our practice.

Senator CURTIS. I would think so; I would think so. Among public officials or anybody else, any professional group, now and then you will find a bad actor, but I can't feel at all that the rank and file of our doctors across the country are recommending and rendering unneeded and unnecessary services just because they are reimbursed on a fee basis.

Dr. WALDEN. Well, this certainly would be true of the black physician who is in such supply in this country. He wouldn't have time to engage in unnecessary things.

Senator BENNETT. Yes.

That is all I will take time for.

Senator JORDAN. One of these other gentlemen had a contribution he wanted to make.

Mr. KIRKPATRICK. With respect to the question of costs, I think very definitely the feeling of the House in this report was that by putting a 95 percent amount that would be spent under medicare and medicaid for people covered they could save some money; and I think there is very definitely a savings idea there and also in the case of medicaid people the intent would be to get welfare people covered under an HMO and have a contract between the Government, the State government, and the HMO and to cover all the medicaid people so there would be very little—freedom of choice would be limited in that category or group.

Senator JORDAN. Yes, and what I was referring to here is the fact that in their report they say because the organization receives a fixed annual payment from enrollees, regardless of the volume of services rendered, there is a financial incentive to control the costs and provide only the least expensive service that is appropriate and adequate for

the enrollee's need. Moreover, such organizations take responsibility for deciding which services the patient should receive and then seeing that those are the services he gets. If that is intended to imply that the individual practitioner does not do that, I would be inclined to disagree with that. That is all.

Dr. CHISSELL. I am a family practitioner, general practitioner. First, let me say it is so refreshing to come in from the front lines and rendering primary care to find out that headquarters is aware of what the problem is.

Before we came here we checked and we found out, for instance, that there are 57 black doctors in the State of Louisiana and if we eliminate those who are in New Orleans and Baton Rouge and those doing surgery and obstetrics and what not, then you would have a problem in that State rendering primary care.

With regard to increasing the number of family practitioners, the Senate and the House in their wisdom passed the Yarborough-Rooney bill which was designed to adjust that, only to have it vetoed; but statistics have shown, for instance, in Oklahoma where there is a well established family practice department in the university and students get equal exposure to family practice as others, you have a 30-percent interest in the student body when they matriculate as freshmen and where they have this exposure and as versus in turn selecting family practice, 30 percent.

On the other hand, schools where there is no exposure, you have the same 30-percent interest but by the time they graduate the interest is not 30 percent.

When the Yarborough-Rooney bill was considering the retention of facilities, and we have an excellent example of what the problem is at Maryland, one which has a family practice department which is attached to the Department of Medicine, University of Maryland. Johns Hopkins has said its students shall not have the choice of being exposed to family practice. They see a family practitioner of the future as being a combination of an internist and pediatrician. We happen to believe any student who goes into medicine has not only the choice but should have the right to look at all of the specialties and the family practice is now the 20th recognized specialty: that student should have the right to look at all 20 and decide for himself what he wants to go into and what he will be happy doing. We don't think that anyone in the country has a right to refuse this because the shortage is just there, too.

Once this family practitioner graduates, and each of you in your states have health departments which focus on—for instance TB and venereal diseases—and there ancillary people—social workers, home health aides, to go out in these areas—if we could support a family practitioner the same way and fund him the same way and fund him with home health aides and social workers and what not, not only treat TB and venereal disease but hypertension, heart disease, cancer, and stroke, we could then reduce the admission rates in hospitals and we have found in Maryland just last year—the secretary of health called a conference and found out if he had more family—had more family practitioners been available in Maryland in the last fiscal year, \$3 million could have been saved by purchasing services from these

men rather than in the hospital emergency room. The projection is it will be \$5 million this fiscal year.

I remind you 39 percent of that is Federal funds so it is at least \$1 million. You multiply that by 50 States and I think you can see where you can find the funds to give people more quality care. So I appeal to you.

Senator JORDAN. I want to ask you at that point, isn't the care the country doctor gives the patient in point of time sooner than the care he gets when arriving at the hospital?

Dr. CHISSELL. Absolutely, because he is a specialist in primary care; this is what he does all the time.

Senator JORDAN. He sees them all the time, if he is a family doctor, which I would assume would result in the savings of some lives?

Dr. CHISSELL. Absolutely, and if we must look at it in cold terms of costs, because funding always seems to be a problem, I don't think there is any argument among any of the medical providers that primary care purchased from people who specialize and deliver primary care is much more reasonable than buying it from tertiary care centers like teaching hospitals. Everyone is agreed on this. The question is, how do you develop it; how do you get the people out to it; and I say the way to do it is call in some of us who have been doing it for years and find out at least what our ideas and opinions are before we pass the law to fund it.

The CHAIRMAN. Well, thank you very much.

(The prepared statement and addendum of the National Medical Association follows:)

STATEMENT OF THE NATIONAL MEDICAL ASSOCIATION

Mr. Chairman and members of the committee, I am Dr. Emerson Walden of Baltimore, Maryland. President of the National Medical Association, the organization which represents the 6,000 Black Physicians of this nation. We of the National Medical Association wish to thank you for granting our request that we be allowed to testify before your Committee and to place in the record our views with regard to H.R. 1, legislation designed to produce or cause far-reaching changes in the methods of health care delivery and the practice of medicine in this country.

With me are Doctors John A. Kenney, Jr., who is Chairman of the Legislative Committee of the Board of Trustees of the National Medical Association; Erman W. Edgecombe, Speaker of the House of National Medical Association both from Washington, D.C.; John T. Chissell, a member of the Committee from Baltimore, Maryland and Mr. Loy Kirkpatrick, Counsel to the Committee and the National Medical Association.

I would first like to summarize the principal points of our testimony and then elaborate upon them in the remaining minute of the time allotted to us for our statement.

First, while we can understand and are to some degree sympathetic with the principal objectives of H.R. 1, we feel that many of its provisions are objectionable from the point of view of the poor and the disadvantaged, whose interest we feel we must speak for and protect since so many black people fall into this category. Thus, we are most opposed to the cutbacks in the Medicaid program which various provisions of H.R. 1 would effect.

Second, while we are not unalterably opposed to the principle of health maintenance organizations (HMO's), we have grave doubts as to their probable ownership (few minority groups would be able to find the capital to participate, as proposed regulations now stand) and also we have grave doubts as to the level of care HMO's would provide to the poor under the provisions of H.R. 1.

Thirdly, we do note with favor certain features of H.R. 1 which liberalize Medicare provisions.

Now please allow me to expand on these principal points with some specifics. We find objectionable those provisions of H.R. 1 which, for economy's sake, would permit States to reduce the scope of their Medicaid programs, even though they would expand Medicare coverage. Specifically we are opposed to Section 230 which would repeal Section 1903 (e) of the Social Security Act (42 U.S.C. 1396 (e)) which forbids the Department of HEW to continue medical assistance grants to States unless a State made a satisfactory showing that it would, by January 1, 1977, provide all possible medical services to all those who would be eligible therefor under relaxed eligibility requirements. We are opposed to Section 231, whose intent is to permit States from one year to another to eliminate optional services such as drugs, dental care and eyeglasses, though retaining certain mandated service, and to section 207 which would reduce payment by the Federal Government to the States by one-third for inpatient hospital and skilled nursing home care in excess of 60 days per fiscal year. We do not like Section 209 (c) which would, among other things, exempt States from any requirement to provide Medicaid coverage either to poor persons who would be covered under the Family Assistance Plan of proposed Title 21 of the Social Security Act, or to the blind, aged or disabled who would be covered under proposed Title 20 of the Social Security Act, and Section 208 (a) which would require the medically needy (Persons sufficiently well off to cover food, clothing and shelter without public assistance but with insufficient income to pay medical bills) to bear enrollment fees, share costs and bear deductible expenses. We feel these sections of H.R. 1 all burden the poor. All of these appear to us to deprive the poor of access to a better supply which is now available to the more affluent members of the population.

With regard to HMO's, we have two principal concerns. In view of Sections 207 and 236 H.R.1, one single HMO, serving both Medicaid and Medicare eligibles, would be limited in the amount of care to be offered Medicaid members but practically unlimited in the care which could be given to Medicare members. We find this patently objectionable. We believe a unitary standard of care is imperative for both Medicaid and Medicare beneficiaries, and certainly very definitely so in the instance when care is to be rendered by one single HMO. Sections 207 and 236 should be amended to allow HMO's operating under Section 207 State contracts and Section 236 Federal contracts the opportunity to provide the most comprehensive health care possible to all its members and subscribers. Such an amendment to these two sections will necessarily require authorization of additional appropriations from the general treasury to cover the difference in costs for Medicaid level services and the actual cost to HMO's for rendering truly comprehensive care to all its members, the same type of care provided by Medicare.

Our reservation regarding HMO financing is this. H.R. 1 provides no financial assistance for the formation of HMO's. Although S. 1182 does provide such assistance, aid is limited to 90% of construction costs. We feel that financial assistance in the form of 100% construction loan guarantees and grants for initial operating costs must be provided by H.R. 1 if some of the very groups whom this legislation should reach—inner-city black groups—are to have the means of owning and operating the health facilities H.R. 1 comprehends in its Section 226. As we read H.R. 1 as it now stands, no such financial aid is contemplated. We feel this is a serious defect and that it should be remedied.

There is much more that I could say but I am sure my time has expired and we shall be glad to answer questions about any of these views, and of course we shall elaborate upon them in our written statement to the Committee. Thank you.

ADDENDUM

The National Medical Association has always acted in a manner to promote the 'good life' for all Americans. This, of course, includes good health and quality health care. In this context, in 1962, we became the first body of organized physicians to support Medicare. Although we felt very proud of our position at a time when professionals generally were opposed to government subsidy of health care needs of various segments of our population, we know that the job is far from being done. Consequently, we reluctantly supported the passage of Medicaid. We felt then, as we do now, that 'tacked on' programs, especially when ill-conceived, fail in their mission when we offer second-class programs to any segment of our population. The relative success between Medicare and Medicaid is like the difference between all segments of our population.

Happily we see trends in the directions. The degree to which this gap has been closed and its rate of acceleration has, in many ways been related to increased Federal activity in the field of health. Not only has there been more and more health legislation, but implementation of major health care programs has moved forward in an unprecedented fashion. The relative success of each program has been far from uniform in quality, both within a given category and between categories. What is of major significance is that several key public policies have been developed regarding the provision of health to citizens in the United States. One of the most lucid, and yet simplest stated concepts marking the shift in policy was stated by the then Surgeon General, William H. Stewart, speaking to the National Health Advisory Council of 1966 in reference to the passage of the "Partnership for Health Act":

"Every person should have ready access to high quality personal health services and every person should live in an environment which is safe from preventable hazard and is conducive to healthful and productive living. The first thrust is to remove the inequities and inadequacies in access to and quality of personal health care. The second is to assure maximum protection against diseases and hazards in the environment."

The aforementioned policy declaration, the implementation of certain programs and the rising tenor of public debate have affected, to some degree, most aspects of society; our people; our institutions; our units of government and our wealth. In recognition of current policies and projected needs, it is clear that some direction is necessary in order to focus more precisely on matching needs with well defined solutions. Hoping to provide this august committee with some thoughts on how that direction can be achieved with regard to H.R. 1.

The CHAIRMAN. Our next witness will be Dr. Dorrity, accompanied by Frank Woolley.

STATEMENT OF THOMAS G. DORRITY, M.D., PRESIDENT, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, ACCOMPANIED BY FRANK K. WOOLLEY, EXECUTIVE DIRECTOR, AAPS

Dr. DORRITY. Mr. Chairman, I am Thomas G. Dorrity, M.D., J.D., president of the Association of American Physicians and Surgeons, and I am in the private practice of medicine, solo practice, under the free enterprise system. I am presently chief of surgery at the Methodist Hospital in Memphis. I have with me Mr. Frank K. Woolley, who is executive director of AAPS.

We would like to request, please, that our entire testimony be included in the record, as well as our oral presentation.

The CHAIRMAN. We will print the entire statement exactly the way you prepared it.

Dr. DORRITY. Thank you, sir.

We, representing the Association of American Physicians and Surgeons, are pleased to appear before you today to give you the benefit of our thinking and work and research on the proposed legislation before you today, H.R. 1.

The Association of American Physicians and Surgeons is opposed to H.R. 1 for many reasons: First, because it increase government spending at a time when local, State, and Federal governments are in a financial crisis and cannot stand more abuse.

Forty-three percent of everyone's earnings are presently being spent by government. The December 1971, Survey of Current Business, by the U.S. Department of Commerce, shows that government is spending \$375 billion out of total income from all sources for everyone of \$854 billion.

Government is running the printing presses to cover the differences between taxes collected and money expended. Many bankrupt State and local governments are depending upon a bankrupt Central Government to save them from bankruptcy.

The accelerated rate of government spending is briefly outlined in table I which is before you. It shows that there has been only a $2\frac{1}{4}$ times increase in population from 1913 to 1972 but that spending by government has increased 855 times. Whereas total government spending for a family of four in 1913 was \$89, expenditures have gone up geometrically so that in 1971 such government spending was \$7,184.

In the face of this calamity, President Nixon is asking for \$245 billion for 1973 fiscal year beginning July 1, 1972, and for a \$50 billion debt ceiling increase to carry out his New American Revolution. In addition, you are considering in H.R. 1 authorizing spending many additional billions which you do not have and which we fear you will not raise except by more inflation.

Unwise welfare spending to build political machines is largely responsible. The facts are:

Current HEW spending \$58.063 billion; request for HEW budget, \$78.9 billion; profits of all corporations after taxes, \$45 billion; Defense Department, \$71.819 billion; personal savings of everyone, \$57.7 billion, and rapidly sinking; gross expenditures for physicians' services, 1971, \$14.2 billion; average expenditures for physicians' services, family of four, \$270; current and proposed Federal deficit, 3 year, \$87 billion; and average deficit for a family of four, \$1,500.

The foregoing facts starkly reveal the enormity of government spending. People living on pensions, savings, and low incomes pay for this cruel irresponsibility on the part of government through higher bills for groceries, clothing, housing, transportation, medical care, and everything else they buy.

To divert attention from the guilt of government in failing to discharge its constitutional responsibility of maintaining the integrity of money, it has decreed price and wage controls endorsed by both major political parties.

Government propaganda says producers of goods and services are to blame for the inflation.

The medical profession has been singled out and unfairly blamed for inflation in the Price Commission's regulations and propaganda. Corporate costs of government redtape passed on to consumers is \$18 billion, which is \$4 billion more than gross payments to doctors for medical care.

Wage and price controls can never stop inflation because they violate basic economic laws. Blaming corporations and doctors is merely a smokescreen to hide the Government's guilt and deception.

Central Government should heal its own sickness of uncontrolled spending, which is its responsibility, instead of interfering in medical care where it is incompetent and has no proper responsibility.

Promising utopia as a means of plundering the people for political power in or outside government to obtain special privilege for particular interest groups is the cause of America's bankruptcy. The phrase "sound as a dollar" is a mockery echoing of unreality.

The political slogan for plundering the Treasury in days past was, "We only owe it to ourselves." Now it is obvious that this is merely

political and economic demagogery. The truth is U.S. citizens are prohibited from owning gold; the price of the dollar is fading as the price of gold rises in the world market; the United States has been exporting its domestic budget deficit to the rest of the world; the United States is suffering a severe balance-of-payment deficit, the first in this century; the Federal Reserve Board has been running the printing presses and watering the currency through its so-called monetizing of the public debt—it is not in control—neither is the U.S. Treasury; when it became clear that the United States had liquidity problems in 1969, the world started reacting to the real crisis in America—the dollar crisis; the jig is up; our gold is gone—Europeans and Japanese have it and world confidence in the dollar is sagging badly due to irresponsible spending by U.S. Government. This is the real crisis.

Always in previous inflations men with big names and fancy titles have assured the people that all is well. When a foreign economics professor with a Ph. D. from Cambridge University bearing the impressive title of “Lord” tells the President of the United States that we can spend ourselves rich, away we go. Lesser celebrities by the thousands join in the chorus and it becomes believable because this siren song of something for nothing is the road to political power. Also, because it is what many people wish to believe.

Now is the time to stop and take inventory, not to plunge on down the road of spending to certain disaster.

The second reason that AAPS opposes H.R. 1 is that it would expand medicare and substantially nationalize medicaid on false premises.

In a Senate report of this committee dated February 9, 1970, after stating and proving that medicare and medicaid programs were adversely affecting health care costs and financing for the general population, the staff concluded:

Unless the rapid and continuing escalation in the cost of health care are moderated, the Congress may reasonably anticipate increasing pressures upon it to extend the medicare and medicaid programs to encompass large segments of the population not now covered under these public health payments plans.

To say that medicare and medicaid are driving up medical costs for everyone and unless we hold down on costs, Congress will expand medicare and medicaid is absurd.

In a country where we have more doctors per 1,000 population than any other major country in the world, government is forcing up medical costs dramatically by unwise spending such as grants luring doctors into questionable research, and away from teaching and away from patient care; also by pushing the worried well into overworked doctors' offices and hospitals by promising care for less than cost.

Enoch Powell, British Minister of Health, 1960 to 1963, who tried diligently to make political interference work under the nationalized health service, now thinks that England irreversibly went down the wrong road. He put his finger precisely on the problem when he spoke to our association in St. Louis recently:

When health care is offered free of charge at the point of consumption, or at less than market price at the point of consumption, the demand is literally unlimited. The conflict is inherent in the system and no one can make it work satisfactorily.

We suggest that you study carefully Mr. Powell's comments in his book, "A New Look at Medicine and Politics."

The third reason that AAPS opposes H.R. 1 is that it would begin a vast new program authorizing government officials to pay lay-dominated organizations predominantly sponsored by labor unions to provide and control medical care for medicare and medicaid patients under bureaucratic regulations. Also, H.R. 1 would authorize subsidizing such organizations with participants under 65 years of age.

All this is done under the deceptive and marketable title of "Health Maintenance Organizations" which would seriously undermine the practice of private medicine.

H.R. 1, which would cost many additional billions and add to inflationary pressures, is not supported by substantial facts.

Its main support is the self-serving propaganda of ambitious bureaucrats and a coalition of other forces dominated by labor union leaders such as the group health association which has promoted this type of legislation for years as a step toward the nationalization of medical care.

Labor union leaders, having only 25 percent of the labor force in unions under their control, and having reached the practical limits of salary and fringe benefits which they can extract from corporations and which corporations can, in turn, pass on to the public, are trying to shift the cost of medical care fringe benefits to government. If they are successful in making the shift by nationalizing medicine, toward which passage of H.R. 1 would be a long step, this will make employers more vulnerable to higher union wage demands, and assist in organizing more workers.

Advocates of the bill actually admit that it is designed to destroy our medical care system that is based on a willing exchange economy.

Through HMO's the bill would authorize arbitrary and unfair discrimination in favor of doctors who practice in groups under direction and control of a combination of labor union and Government employees. This would adversely affect both individual doctors and groups of doctors not under such direction and control.

HMO's would condone imposition by bureaucrats of controls over any compensation of any persons providing health services. Controls would apply to private patients as well as those on a Government dole. This would violate the code of ethics of the medical profession and also would violate congressional promises that bureaucrats would be prohibited from interfering in medical practice or compensation for it. (See section 1801 of Public Law 89-97 and congressional debates relating thereto.)

The House report on H.R. 1 says that the legislation assumed that all individuals are too dense to find their way around and only groups of doctors under labor union and governmental direction should ration medical care and push recipients around as incompetents.

Astutely, labor union leaders are maneuvering some doctors and lay medical society executives with a few crumbs such as grants-in-aid for peer review, computers, medical foundations and areawide planning, to embrace controls manipulated by those labor union leaders and their sympathizers in Government.

Some doctors practicing in groups on a fee-for-service basis mistakenly believe that they can outmaneuver the labor-government-

bureaucrat coalitions, control medical practice under a collectivist scheme and continue much as at present. Labor unionist and Government bureaucrats promoting this deception are pleased that the medical association bureaucrats are taking the bait.

Many Congressmen and some businessmen are being misled to believe that health maintenance organizations would (1) prevent medical disorders; (2) provide better and more care than is being provided; and (3) lower costs.

There is no objective evidence to support such claims.

First, potential additional benefits through preventive medicine are quite limited. The medical profession does not know how, and no one else knows how to prevent many disorders which constitute a high percentage of reasons that patients seek medical care. To mention only a few: accidents by the millions, primarily with automobiles related to abuse of alcohol and/or drugs, asthma, arthritis, cardiovascular disease, diabetes, endometriosis, emphysema, gall bladder disease, malignant skin growths, marital problems, migraines, neurosis, slipped discs, et cetera. Man's health is threatened by drug abuse, smoking, physical indolence, obesity and other disorders which go far beyond traditional services of physicians, dentists, et cetera. The primary responsibility for health maintenance belongs to the individual and no trick of legislation can change this fundamental fact.

Second, the great advances in medicine are applicable to only a small percentage of patients. The vast majority of patients seeing doctors want help with the discomforts of a limited illness or to learn how to deal with a chronic illness or assurance from certain anxieties.

For most of these problems, the personal compassion of a trained physician, free and determined to do his best and not acting under the duress of bureaucratic control, remains the best medical care. Assemblyline medicine rationed by an HMO for maximum profit is not what the patients want or need. After years of free service and the soporific influence of the welfare state, there are a great many people in England prepared to pay their doctor in order to be properly looked after.

The fundamental principle in medicine is *primum non nocere*—in the first place, do no harm. Others in society could do well by accepting such a basic principle.

Third, the cost of prepayment per capita group practice is expensive and will not lower costs. Kaiser-Permanente is often cited favorably as an example of a successful HMO; yet, in the past few weeks it was granted a 10.3 percent increase by the Price Commission, a percentage which was added to three prior increases for the immediately preceding 3 years, for a total of 38 percent.

Serious questions are being raised as to advocating increased medical care in reducing disease, disability and death. The impact of medical care on health seems even less likely to be effective on the poor than on the average person, since the poor person's health will be more negatively influenced by poor sanitation, poor nutrition, inadequate housing and generally undesirable living conditions, regardless of any improvements in medical care that might be made available to him.

Surely, more inflation which cruelly grinds the poor the hardest will not aid the poor in supplying their many needs for better health.

It is a merciless hoax on the poor to build health maintenance organizations for unionists and bureaucrats, paid for out of deficit financing which penalizes the poor more than anyone else.

Seducing and driving patients and doctors into unionist and bureaucratically controlled collectives, further burdening doctors with red-tape, diverting them by duress from doing their best for their patients, is wrong. This is one sure way of lowering medical care below what it otherwise would be.

Sidney R. Garfield, M.D., director of the Kaiser Foundation, said: "We believe the choice of alternative systems, including solo practice, is preferable for both the public and physicians. Any change to prepaid group practice should be evolutionary, not revolutionary."

We submit that subsidizing one type of practice over the other is revolutionary, unfair and not in the interests of patients or physicians.

The bill should be stripped of all subsidies and special privileges for per capita prepayment group practice. Likewise, no subsidy should be added to pay medical societies or medical foundations to become policemen for Federal Government medical programs which cannot work satisfactorily.

We applaud the stand of Governor Reagan before this committee in rejecting nationalization of welfare, and insisting that welfare is a State and local responsibility which should not be preempted by, or surrendered to, the Central Government.

We encourage this committee to live up to its constitutional duty and responsibility for restraining the bureaucracy before it delivers us to the enemies of free men by destroying our private, capitalistic system.

Thank you.

Mr. Chairman, we would like the privilege of submitting supplementary testimony for the record.

The CHAIRMAN. Fine.

Any questions?

Senator CURTIS. Doctor, from the standpoint of the patient, what do you think are the objections to the HMO—the health maintenance organization?

Dr. DORRITY. It is third-party interference, Senator Curtis, and I think anytime you allow or force a third party to interfere in the doctor-patient relationship you divide allegiance, you divide loyalty and you lower the quality of medical care. There is no substitute for allowing the doctor to exercise his best judgment for his patient, excluding all third parties.

Senator CURTIS. It divides the responsibility, too, does it not?

Dr. DORRITY. Yes, sir.

Senator CURTIS. I was impressed by your comment here that preventive medicine was oversold and you mentioned a long list of ailments, including arthritis, asthma, abuse of alcohol, diabetes, gall bladder disease, migraines, neurosis and many others, that medicine did not know how—didn't have any answer from the preventive standpoint. I think that is quite significant, because the idea has been put forth that if medicine was turned over to a group and somehow a flat fee paid by somebody, and because medical services would be available a great amount of illness would be prevented. And I take it your contention is that just isn't so?

Dr. DORRITY. Absolutely not; no, sir. Medical service is available; it has always been available. I think part of the problem is a lack of education. People know—most of them do—that they can go to a physician for advice, counsel and treatment, without having to go through third parties or through groups. In the groups, the responsibility is divided and a patient may not see the same doctor in two or three trips a year.

Senator CURTIS. Are you familiar with the operation of some of these existing HMO's?

Dr. DORRITY. Yes, sir, and with some of the foundations, which are about the same in principle and the kind of thing that a lot of socializers have been trying to impose on us since about 1930.

Senator CURTIS. How are the doctors paid by these HMO's?

Dr. DORRITY. It depends on the way they are set up. You can set up these foundations any way you want to, but eventually the doctors are employees of the foundation. The foundation parcels out the pay to the various physicians participating. The foundation bills the individuals and/or the corporations or the unions for whatever this group of politicians or labor unions or private insurance companies are allowed to charge; payment is made to the foundation and then the foundation doles it out to the participating doctors.

Senator CURTIS. Is it on a salaried basis or a share in the profits or a combination of both?

Dr. DORRITY. Some of them pay both; but it depends on how much comes in. If they agree that salaries will be divided at a certain level and there is not enough in the kitty, they can't operate on deficit spending like the Government; they either have to borrow, or cut the salaries.

Senator CURTIS. In the operation of these health maintenance organizations, does the patient get to see the same doctor over and over again?

Dr. DORRITY. No, sir; they divide up the time as to who is on duty. I think it would be the exception rather than the rule if a patient got to see the same physician on each trip to see a doctor.

Senator CURTIS. What position with what hospital did you refer to in your opening remarks you were associated?

Dr. DORRITY. I am chief of surgery at the Methodist Hospital in Memphis, Tenn.

Senator CURTIS. How large a hospital is it?

Dr. DORRITY. It is about 1,000 beds.

Senator CURTIS. Do you have any sort of voluntary peer review in that hospital and in the environs where you practice medicine?

Dr. DORRITY. We have always had peer review, Senator Curtis, where we review doctors' work through our physicians committees, our utilization committees, our ethics committees, our grievance committees. This has always been in effect. I have been actively associated with such review since 1941 and this has never been a problem. We always have had it. I think it is good to have a peer review where doctors review doctors and doctors' work for doctors to see how to improve quality care.

Senator CURTIS. What is the difference between having peer review worked out by the doctors, such as you have experienced and peer review imposed by Federal legislation and—

Dr. DORRITY. That imposed by Federal legislation would be designed to try to get doctors to control costs of medical care. This is reviewing doctors for some third party, and Government is the third party. I think that is wrong—especially to put the burden on the doctors to control costs of what Government calls health care.

Doctors can render medical care only; doctors cannot render health care as defined by the World Health Organization, for example, which includes food, clothing, lodging, money in the pocket, mental attitude, garbage disposal, et cetera. Doctors couldn't deliver this kind of care even if they wanted to; they can deliver medical care only.

Senator CURTIS. The way the peer review has been presented here, I have felt that it was different from the peer review that doctors and hospitals worked up for themselves.

Dr. DORRITY. We have always had peer review, but since medicare and medicaid the push has been to force doctors to attempt to control health care costs, and some of them have mistakenly accepted this responsibility. But this can't be done by the doctors.

Senator CURTIS. That is all the questions I have, Mr. Chairman.

The CHAIRMAN. Any further questions?

Senator HANSEN. Dr. Dorrity, are a number of the members of the Association of American Physicians and Surgeons also members of AMA?

Dr. DORRITY. Yes, sir.

Senator HANSEN. Would you know if it would be generally true that the American Medical Association consensus would reflect agreement with your statement here today?

Dr. DORRITY. We would have no way of knowing that, but I think most of them will.

Now, when AMA advocates medicredit, they are not speaking with the knowledge and consent of all the doctors. I know many, many doctors who are opposed to this, some even to the point of saying, "I shall not, will not, pay dues to AMA again for this reason." Advocates of medicredit accept the premise that socialism is inevitable, and that we have got to learn to live with it. I don't think it is; I don't think we are whipped unless we give up, and I think this is wrong.

Senator HANSEN. Well, let me say that it is refreshing to have demonstrated the courage and forthrightness that you have exhibited here today. I thought you were a vanishing breed. Maybe you are not. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Nelson?

Thank you very much gentlemen.

(Statement of Association of American Physicians and Surgeons presented by Dr. Dorrity follows. Hearing continues on p. 2662.)

STATEMENT OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS,
PRESENTED BY THOMAS G. DORRITY, M.D., PRESIDENT

SUMMARY

The AAPS is opposed to HR-1

FIRST because it increases government spending at a time when local, state and federal governments are in a financial crisis and cannot stand more abuse. 43% of everyone's earnings are presently being spent by government. See December, 1971 *Survey of Current Business* by the U.S. Department of Com-

merce which shows government is spending \$374 billions out of total income from all sources for everyone of \$854 billions. Government is running the printing presses to cover the difference between taxes collected and money expanded. Many bankrupt state and local governments are depending upon a bankrupt central government to save them from bankruptcy.

The accelerated rate of government spending is briefly outlined in Table I which is before you. It shows there has been only a $2\frac{1}{4}$ times increase in the population from 1913 to 1972, but the spending by government has increased 855 times. Whereas, total government spending for a family of 4 in 1913 was \$89.00, expenditures have gone up geometrically so that in 1971 such government spending was \$7,184.00.

In the face of this calamity, President Nixon is asking for \$245 billions for 1973 fiscal year beginning July 1, 1972 and a \$50 billions debt ceiling increase to carry out his "New American Revolution." In addition, you are considering in HR-1 authorizing spending many additional billions which you do not have and which we fear you will not raise except by more inflation. Unwise welfare spending to build political machines is largely responsible for the crisis we face. The facts are:

	<i>In billions</i>
Current HEW spending-----	\$58. 063
Request for HEW (budget)-----	78. 9
Profits of all corporations after taxes-----	45. 0
Defense Department-----	71. 819
Personal savings of everyone-----	57. 7
Gross expenditures for physicians' services, 1971-----	14. 2
Average expenditures for physicians' services, family of 4-----	270. 00
Current and proposed Federal deficit (3 year)-----	87. 0
Average deficit for a family of 4-----	1, 500. 00

The foregoing facts starkly reveal the enormity of government spending. People living on pensions, savings, and low incomes, pay for this cruel irresponsibility on the part of government through higher bills for groceries, clothing, housing, transportation, medical care, and everything they buy. To divert attention from the guilt of government in failing to discharge its constitutional responsibility of maintaining the integrity of money, it has decreed price and wage controls endorsed by both major political parties. Government propaganda says producers of goods and services are to blame for the inflation. The medical professional has been singled out and unfairly blamed for inflation in Price Commission's regulations and propaganda. Corporate costs of government red tape passed on to consumers is \$18 billions which is \$4 billions more than gross payments to doctors for medical care. Wage and price controls can never stop inflation because they violate basic economic laws. Blaming corporations and doctors is merely a smokescreen to hide the government's guilt and deception. Central government should heal its own sickness of uncontrolled spending—which is its responsibility—instead of interfering in medical care where it is incompetent and has no proper responsibility.

Promising Utopia as a means of plundering the people for political power in or outside government to obtain special privilege for particular interest groups is the cause for America's bankruptcy. The phrase "sound as a dollar" is a mockery, echoing of unreality. The political slogan for plundering the Treasury in past days was "We Only Owe It to Ourselves."

Now it is obvious this is merely political and economic demagoguery. The truth is:

U.S. citizens are prohibited from owning gold.

The price of the dollar is fading as the price of gold rises in the world market.

The U.S. has been exporting its domestic budget deficit to the rest of the world.

The U.S. is suffering a severe balance of payments deficit, the first in this Century.

The Federal Reserve Board has been running the printing presses and watering the currency through its so-called monetizing of the public debt. It is not in control. Neither is the U.S. Treasury.

When it became clear that the United States had liquidity problems in 1969, the world started reacting to the real crisis in America—the dollar crisis.

The jig is up. Our gold is gone. Europeans and Japanese have it and world confidence in the dollar is sagging badly due to irresponsible spending by U.S. governments. This is the real crisis.

Always in previous inflations men with big names and fancy titles has assured the people that all's well. When a foreign economics professor with a Ph. D. from Cambridge University bearing the impressive title of "Lord" tells the President of the United States we can spend ourselves rich, away we go! Lesser celebrities by the thousands join in the chorus and it becomes believable because this siren song of something for nothing is the road to political power. Also, because it is what many people wish to believe.

Now is the time to stop and take inventory—not plunge on down the road of spending to certain disaster.

The *SECOND* reason, is that HR-1 expands Medicare and substantially nationalizes Medicaid on false premises.

In a Senate Report of this Committee dated February 9, 1970 after stating and proving that Medicare and Medicaid programs were adversely affecting health care costs and financing for the general population the staff concluded:

"Unless the rapid and continuing escalation in the cost of health care are moderated, the Congress may reasonably anticipate increasing pressures upon it to *extend the Medicare and Medicaid programs* to encompass large segments of the population not now covered under these public health payments plans." (underlining supplied)

To say: "Medicare and Medicaid are driving up medical costs for everyone and unless we hold down on costs, Congress will expand Medicare and Medicaid" is absurd!

In a country where we have more doctors per thousand than any other major country in the world *government* is forcing up medical *costs* dramatically by unwise spending such as grants luring doctors into questionable "research," away from teaching and away from patient care. Also, pushing the worried-well into overworked doctors' offices and hospitals by promising care for less than cost.

Enoch Powell, British Minister of Health 1960-1963 who tried diligently to make political interference work under the Nationalized Health Service now thinks England irreversibly went down the wrong road. He put his finger precisely on the problem when he spoke to this Association in St. Louis recently:

"When health care is offered free-of-charge at the point of consumption or at less-than-market-price at the point of consumption, the demand is literally unlimited. The conflict is inherent in the system, and no one can make it work satisfactorily."

We suggest you study carefully his comments in a book *A New Look at Medicine and Politics*.

The *THIRD* reason for opposing HR-1 is that it would begin a vast new program authorizing government officials to pay lay dominated organizations sponsored by labor unions to provide and control medical care for Medicare and Medicaid patients. Also, it would authorize subsidizing such organizations with participants under 65 years of age. All this is done under the deceptive and marketable title of "Health Maintenance Organizations." This would seriously undermine the practice of private medicine.

This bill which would cost many additional billions and add to inflationary pressures is not supported by any substantial facts. Its main support is the self-serving propaganda of ambitious bureaucrats and a coalition of other forces dominated by labor union leaders such as the Group Health Association which has promoted this legislation for years as a step toward nationalization of medical care. Labor union leaders with only 25% of the labor force in unions under their control, having reached the practical limits of salary and fringe benefits which they can extract from corporations and which the corporations, in turn, can pass on to the public, are trying to shift the load of medical care fringe benefits to government. If they are successful in making the shift by nationalizing medicine, toward which HR-1 is a long step, this will make employees more vulnerable to higher union wage demands and assist in organizing more workers.

Advocates of the bill actually admit it is designed to destroy our medical care system based on a willing exchange economy.

Through HMO's the bill would authorize arbitrary and unfair discrimination in favor of doctors practicing in groups under direction and control by a combination of labor union and government employees. This would operate against

both individual doctors and groups of doctors not under such direction and control.

It would condone bureaucrats imposing controls over any compensation of any persons providing health services. This would apply to private patients as well as those on a government dole. This would violate the Code of Ethics of the medical profession and, also, would violate congressional promises that bureaucrats would be prohibited from interfering in medical practice or compensation for it. (See Section 1801 of P.L. 89-97 and Congressional Debates relating thereto.)

The House Report says the legislation assumed all individuals are too dense to find their way around and only groups of doctors under labor unions and government direction should ration medical care and push recipients around as incompetents.

Astutely, labor union leaders are maneuvering some doctors and lay medical society executives with a few crumbs, such as grants in aid for Peer Review, computers, medical foundations, and area-wide planning, to embrace controls manipulated by those labor union leaders and their sympathizers in government.

Some doctors practicing in groups on a fee-for-service basis mistakenly believe they can out-manuever the labor and government bureaucratic coalition, control medical practice under a collectivist scheme and continue much as at present. The labor unionists and government bureaucrats promoting this deception are pleased that the medical association bureaucrats are taking the bait.

Many Congressmen and some businessmen are being misled to believe that Health Maintenance Organizations—would:

- (1) Prevent medical disorders
- (2) Provide better and more care than is being provided, and
- (3) Lower costs.

NO EVIDENCE

There is no objective evidence to support such claims.

First, potential additional benefits through preventive medicine are quite limited. The medical profession does not know how to prevent many disorders which constitute a high percentage of reasons that patients seek medical care. To mention only a few, accidents by the millions, primarily with automobiles related to abuse of alcohol, asthma, arthritis, cardiovascular disease, diabetes, endometriosis, emphysema, gall bladder disease, malignant skin growths, marital problems, migraines, neurosis, slipped discs, etc. Man's health is threatened by drug abuse, smoking, physical indolence, obesity, and other disorders which go far beyond traditional services of physicians, dentists, etc. The primary responsibility for health maintenance belongs to the individual, and no trick of legislation can change this fundamental fact.

Second, the great advances in medicine are applicable to only a small percentage of patients. The vast majority of patients seeing doctors want help with the discomforts of a limited illness, or to learn how to deal with a chronic illness, or assurance for certain anxieties.

For most of these problems, the personal compassion of a trained physician free and determined to do his best and not acting under the duress of bureaucratic control remains the best medical care. Assembly-line medicine rationed by an HMO for maximum profit is not what he wants or needs. After years of "free" service and the soporific influence of the welfare state there are a great many people in England prepared to pay their doctor in order to be properly looked after.

The fundamental principle in medicine is "primum non nocere" (in the first place, do no harm). Others in society could do well by accepting such a basic principle.

Third, the cost of prepayment per capita group practice is expensive and will not lower costs. Kaiser-Permanente is often cited favorably as an example of a successful HMO. Yet, in the past few weeks, it was granted a 10.3% increase by the Price Commission, a percentage which was added to 3 prior increases for the immediately preceding 3 years for a total of 38%.

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We applaud the stand of Governor Reagan, before this Committee, rejecting nationalization of welfare and insisting that welfare is a state and local responsibility which should not be pre-empted by or surrendered to the central government.

We encourage this Committee to live up to its constitutional duty and responsibility for restraining the bureaucracy before it delivers us to the enemies of free men by destroying our private capitalistic system.

STATEMENT

THE AAPS

The Association of American Physicians and Surgeons is a free, independent, non-governmental, voluntary organization of members of the medical profession. We are united for the purpose of analyzing our problems and formulating action to advance and protect the individual responsibility and freedom of doctors and patients thru the practice of private medicine in a willing-exchange economy.

The Association is nationwide with membership in all 50 states, Puerto Rico and the District of Columbia. It is nonpartisan, nonsectarian, and nonsecret in character.

The members are dedicated to :

The ethics of the Physicians' Oath of Hippocrates to which medical doctors have bound themselves for over 2,000 years ; and,

The principles of individual liberty, to which the founders of the U.S. of America pledged their lives, fortunes and sacred honor.

The members :

Cherish the free and complete exercise of their best independent medical judgment solely in the service of their individual patients ;

Will not compromise responsibility to a patient as the result of accepting money through government ;

Guard against intrusions by third parties into the doctor-patient relationship ;

Trust patients to meet their obligations ; and,

Otherwise conduct themselves to advance, not retard, the cause of personal liberty in America.

THE FINANCIAL CRISIS

We are being told there is a health care crisis. And the answer to it is nationalized medicine with government paying the bill and directing the allocation of resources, including telling doctors where they should work. HR-1 is a step in that direction. However, there is a real crisis ; and it is that the federal government is broke ; state governments are broke and, nevertheless, refuse to recognize the truth. Big, monstrous government is destroying the individual. 43%

of everything everyone earns in this country today is being spent by government. Government spending is the primary cause of inflation, which is increasing at an alarming rate despite government statistics to the contrary. Demands for increasing government spending for manufactured "crisis" after "crisis" would, if only met partially, push government spending for the coming year to over 50% of everything everyone earns.

ACCELERATING GOVERNMENT SPENDING

Any believer in fiscal responsibility by government should be gravely shaken by the accelerating pace of government spending briefly outlined in the Table below:

TABLE I

Year	Population (millions)	Spending				Total Government, per family of 4
		Federal		State and local		
		Total (millions)	Per family of 4	Total (millions)	Per family of 4	
1913.....	95,331	\$0,970	\$28	\$2,245	\$61	\$89
1922.....	108,541	3,763	124	5,534	148	272
1932.....	124,149	4,266	60	8,171	156	216
1942.....	133,402	35,549	400	10,027	288	688
1952.....	156,954	71,568	1,648	28,278	536	2,184
1962.....	186,656	113,428	2,064	52,811	960	3,024
1971.....	210.00	224.00	4,300	150.00	2,884	7,184

Source: Facts and Figures on Government Finances Tax Foundation, Inc., 1967, pp. 23, 37, and Survey of Current Business, December 1971.

The Table shows that only a $2\frac{1}{4}$ times increase in population occurred from 1913 to 1972; but spending by government per family has increased 855 times. The Dec., 1971 Survey of Current Business, U.S. Department of Commerce shows the income of everyone before taxes is only \$854 billions (p. 10) with government spending \$374 billions (p. 12). Total government spending is 43% of everything everyone earns before taxes.

President Nixon is asking for \$245 billions which includes \$78 billions for HEW alone—a \$20 billion increase from 1971 spending.

	<i>In billions</i>
Current HEW spending-----	¹ \$58,063
Request for HEW-----	² 78.0
Profits of all corporations after taxes-----	³ 45.0
Defense Department-----	⁴ 71.819
Personal savings of everyone-----	⁵ 57.7
Gross expenditures for physicians' services, 1971-----	⁶ 14.2
Average expenditures for physicians' services, family of 4-----	⁷ 270.00
Current and proposed Federal deficit (3 year)-----	⁸ 87.0
Average deficit for a family of 4-----	1,500.00

¹ Survey of Current Business, December 1971, U.S. Department of Commerce, p. 8-18.

² New York Times, January 25, 1972, p. 1.

³ Survey of Current Business, December 1971, U.S. Department of Commerce, p. 10.

⁴ Ibid., p. 8-18.

⁵ Ibid., p. 11.

⁶ Social Security Bulletin, January 1972, p. 3.

⁷ Ibid., p. 7.

⁸ New York Times, January 25, 1972, p. 1.

The foregoing facts starkly reveal the enormity of government spending. Government is running the printing presses to monetize the difference between taxes and expenditures. People living on pensions, savings, and low incomes, pay for this irresponsibility on the part of government through higher bills for groceries, clothing, housing, transportation, and everything they buy. To divert attention from the guilt of government in failing to discharge its constitutional responsibility of maintaining the integrity of money, it has decreed price and wage controls endorsed by both major political parties. Government propaganda says producers of goods and services are to blame for the inflation. Honest people with

knowledge of the facts know government is to blame. Every dollar wasted by government through taxes or through deficit spending cheats the people. Blaming corporations and doctors is merely a smokescreen to hide the government's deception.

HR-1

The legislation before you, HR-1, is a conglomerate mess of remotely related subject matter which, in itself, constitutes irresponsible legislative activity. It increases federal expenditures under OASDI; initiates subsidies and special privilege to certain groups of doctors; assigns those privileged groups the right to ration hospital and medical care; and furthermore, to profit by limiting the amount of care provided, provides for subsidizing groups to act as policemen for HEW and is another step toward nationalized medicine; provides for building child care centers; radically changes A.F.D.C. to an income without work plan called "The Family Assistance Plan," and otherwise increases tremendously inflationary spending.

It is so complex that few, if any, can understand its ramifications and implications. Prudence suggests it be broken into homogenous subject matter, and each part be considered separately on its own merits, if any. At this stage of wild, reckless, irresponsible and inflationary spending another blow to our economy through an omnibus bill like this is particularly unwelcome.

This spending is being forced upon the American public by a coalition of labor union leaders, legislators espousing their cause and legislators willing to compromise with them. Also, businessmen who are deceived by propaganda and short term considerations, many government employees in HEW, some University professors, and agents of government such as Blue Cross, Blue Shield and some insurance companies. Included in this group are a few doctors who work on salary or expect to profit by the arrangements. There are also medical society executives who have decided to go the collectivist route and similar people who think the way to get along is to go along regardless of the consequences. All are too unenlightened to understand the irresponsibility of their actions.

Labor union leaders having extracted the maximum through "fringe" benefits of hospitalization and physician care hope to shift this load to government and get more wages from employers. And, of course, this will advance the International Labor Organization's objectives of nationalized medicine along "progressive" lines.

THE GAME OF PRETENSE AND DECEPTION

Tragically, the U.S. Congress, the Presidency, and the Executive Branch are caught up in a huge game of deception. The pretense is that government can deliver Utopia and happiness to the American people if it just spends more money and controls the providers of goods and services. Such deception, of course, is a way of life to the average director of the federal or state bureaucracy who must spend every dollar appropriated or be held in contempt by other office holders or members of the Legislative Committees having jurisdiction over the subject matter or appropriations for it. Principle is being abandoned for the expediency of "the way to get along is to go along with the deception and compete for more political power in or outside government to obtain special privileges for a particular interest group." We are face to face with the reality that our system based upon the principles of individual responsibility and freedom is being destroyed by this deception.

The President of the United States calling for a new "American Revolution" apparently is merely promoting the same old big government scheme of destroying the right of individuals to choose how they will conduct their own private affairs. Obviously, this is not the way to Utopia but the way to regimentation and control from the top down which is the system that our forefathers fled from to establish a new free world where the individual was master and government was servant. The promise of Utopia is bankrupting America. The phrase "sound as a dollar" is a mockery, echoing of unreality. The political slogan for plundering the Treasury in days past was "We Only Owe It To Ourselves." Obviously, this is just political and economic demagoguery. The truth is:

U.S. citizens are prohibited from owning gold.

The price of the dollar is fading as the price of gold rises in the world market.

The U.S. has been exporting its domestic budget deficit to the rest of the world.

The U.S. is suffering a severe balance of payments deficit, the first in this Century.

The pretense that the Federal Reserve Board could monetize the public debt and bring prosperity through inflation is exposed for the fraud that it is.

The Federal Reserve Board is not in control.

When it became clear that the U.S. had liquidity problems in 1969, the world started reacting to the real crisis in America—the dollar crisis.

The jig is up; our gold is gone; and the Europeans and Japanese have it.

Foreign banks now are in control of the situation.

Always, in previous inflations, men with big names and fancy titles have assured the people that all's well. Is it any different now? Apparently not! Take a Professor of Economics with a Ph. D. for instance, he is supposed to know what he is talking about. Have him identified with a famous Institute of learning, such as Cambridge University, and then have his government bestow on him the impressive title of "Lord." Now let this man tell the President of the United States that we can spend ourselves rich, and away we go? Somewhat lesser celebrities by the thousands join in this chorus—take up the same theme—and it becomes believable.

Believable? Why? Because this siren song of something for nothing is what many people wish to believe. Their beliefs are formed by others as they join the parade that promises the most for the least exertion. "The great bulk of people infinitely prefer the continuance of a problem which they cannot explain to an explanation which they cannot understand."

If the debauchery of inflation is not to repeat itself in the United States, how are we going to stop the current plunge into disaster? The answer is clear: Only when there is an effective consensus favoring a reversal in government spending. This will come only when it is understood that the responsibility of government is not to insure welfare, security, prosperity, by pushing individuals around as political puppets of a bureaucracy drunk with power, but its proper role is to invoke a common justice by acting as an impartial referee among citizens free to contract among themselves and defend against foreign aggression so that responsible individuals can be their own masters and live with dignity in peace.

NOW IS THE TIME TO STOP

If we do not want to commit national suicide, the place to start is by stopping the additional subsidies and regimentation contained in HR-1.

MEDICARE AND MEDICAID

A report of this Committee dated February 9, 1970 states:

"The Medicare and Medicaid programs are in serious financial trouble. The two programs are adversely affecting health care costs and financing for the general population."

The Senate Finance Committee staff submitted evidence to prove these assertions.

People were promised medical services would be paid for them by government, even though individually they would not have sought the medical care if they had had to pay for it themselves. Yet, the Committee staff after saying Medicare and Medicaid are causing the cost of medical care to go up for the general population, conclude:

"Unless the rapid and continuing escalation in the cost of health care are moderated, the Congress may reasonably anticipate increasing pressures upon it to *extend the Medicare and Medicaid programs* to encompass large segments of the population not now covered under these public health payment plans." (Italic supplied)

Let's examine this logic. The syllogism: "Medicare and Medicaid are driving up medical costs for everyone—unless we hold down on costs, Congress will expand Medicare and Medicaid," is absurd!

Enoch Powell, British Minister of Health 1960-1963 who tried diligently to make political interference work in England under the nationalized health service, now thinks England irreversibly went down the wrong road. He put his finger precisely on the problem when he spoke to this Association in St. Louis recently:

"When health care is offered free-of-charge at the point of consumption or at less-than-market-price at the point of consumption, the demand is literally unlimited. The conflict is inherent in the system, and no one can make it work satisfactorily."

SUBSIDIZING PER CAPITA PREPAID GROUP PRACTICE

(Health Maintenance Organizations—HMO's)

Despite the fact that Medicare and Medicaid are wasting billions of dollars and cannot be made to work satisfactorily because they are encouraging unlimited demand, the legislation calls for subsidies to closed panel per capita prepayment group practice. This scheme is deceptively given a more marketable title of "Health Maintenance Organizations." Advocates of nationalized medicine have promoted this concept since 1927. Its roots go back to Bismarck and the 19th Century long before modern medicine.

This subsidy is particularly objectionable since it undermines the practice of private medicine and is of highly questionable constitutional validity. When the medical profession in 1965, and before, vigorously protested that Medicare would provide the basis for interfering in the practice of private medicine Congress undertook to allay those fears by the following prohibition in the law:

"PROHIBITION AGAINST ANY FEDERAL INTERFERENCE"

"Nothing . . . shall be construed to authorize any federal . . . employee to exercise any supervision or control over the practice of medicine or . . . compensation of any . . . person providing health services . . ." (Section 1801 of P.L. 89-97)

Despite such clear and reassuring language, the Department of Health, Education, and Welfare has issued regulations: and through its Blue Shield, Blue Cross and nominally private insurance company agents, is doing what the law makers said would be prohibited.

Individual physicians practicing ethical medicine have been harassed, dismissed from medical staffs and had their patients notified by government agents the compensation they are charging is unreasonable even though this was untrue. To right such injustices, a physician would have to stop caring for patients and spend months fighting through political red tape before even being allowed access to the courts. Then the calloused federal bureaucracy with unlimited resources makes it grossly unfair to obtain justice. Many physicians are stopping private practice or considering doing so rather than submit to such insults. Others are abandoning care of patients and seeking government or salaried jobs in business. Meanwhile, overworked doctors remaining in practice are being forced to turn away new patients. The House, rather than protect the practice of private medicine and insist on a hands off policy by the bureaucracy, is plunging on into more controls and says in the Report of the House Ways and Means Committee that:

"a serious problem in the present approach to payments for services in the health field . . . either *by private patients* . . . or government is that . . . there is an economic incentive . . . of providing more services . . . that may not be essential . . ."

Thus, the House is saying it not only intends to continue to condone bureaucratic harassment of physicians, but it intends to interfere deliberately with payments by *private patients*.

Additionally, the House Committee says:

"A second major problem is that ordinarily, the individual must largely find his own way . . ."

It then complains:

"No one takes responsibility . . . for determining the appropriate level of care in total and foreseeing that such care, but no more, is supplied."

The Committee goes on to say:

"The pattern of operation of Health Maintenance Organization's that provide services on a per capita prepayment basis lends itself to a solution of both of these problems . . ."

"Because the organization receives a fixed annual payment from enrollees regardless of the services rendered, there is a financial incentive to control costs and to provide only the least expensive service . . ."

"Moreover, such organizations take responsibility for deciding which services the patient should receive and then see that those are the services he gets."

This is saying government is going to subsidize doctors arbitrarily who practice in groups under government dictation and control against individual doctors and groups who do not submit to government interference. The subsidy is to

provide a profit to such groups which hold down services below what patients would receive if they paid doctors privately.

This raises serious questions—

First, judging from the inordinate expenditure of public funds to enroll people over 65 in Medicare and the forcing of insurance companies to drop policies for people who could afford them, the bureaucracy will flood the country with propaganda to sign up with prepaid groups.

Second, how is a patient going to fare in trying to get justice from a bureaucracy that has paid a group of doctors to profit by not giving the patient the care he thinks he needs?

Third, have we come to the point of doubting the capacity of normal individuals in this country to find their way around? If so, then surely our system is doomed, since it relies on ordinary individuals' electing members of Congress. If it can't do one, surely it can't do the other.

Fourth, is it fair for government to reward *subservient* doctors practicing in groups against *independent* doctors practicing either in groups or individually? Who gave government authority to do this?

Fifth, is it fair for government to give a subservient group of doctors a profit to ration care to patients?

DESTRUCTION OF OUR MEDICAL SYSTEM

We call your attention to the fact that recently in hearings on S-1182 "The Health Maintenance Organization Assistance Act of 1971" unequivocal statements were made by spokesmen for labor union leaders that they intend to destroy the United States system of medicine. The United States system is a part of a willing exchange market economy that has grown naturally in the United States without central government interference.

Senator Kennedy in opening the hearings on S-1182 said:

"The real challenge to us . . . lies in creating a *new system* of health delivery. . . ."

"We need legislation which reorganizes the *system* . . . is going to take a drastic overhaul of our entire way of doing business in the health care field. . . .

"This Committee intends to report out legislation designed to change the health care system."

In that hearing labor union leader Melvin A. Glasser said:

"We believe it is concisely important that the system of the organization and delivery of the health system in this country be reconstructed."

The spokesman for the Group Health Association of America, which is a part of the labor union movement, said:

"Appropriate physicians must be convinced to give up their current practices and to make *change*."

Mr. Glasser was delighted with the hearings. He said:

"Our stake in them is substantial. Two years ago President Nixon recognized the growing health care danger when he said and I quote—'We face a massive crisis'"

Mr. Glasser added:

"The cornerstone of the Administration's program . . . is the Health Maintenance Organization. The President's health message: and the testimony of Secretary Richardson and Assistant Secretary DeVale warms the hearts of many of us who, for a number of years, have been pointing to the advantages of prepaid group practice, . . ."

Mr. Glasser admits the program is economically unsound but, nevertheless, intends to get more than it earns. He said:

"In any number of communities where we have attempted to develop Prepaid Group Practice we found that . . . the economics of the industry . . . would not provide sufficient premiums to cover the cost of the HMO program."

Mr. Glasser made a comment which is quite important in the light of what labor union leaders are planning for HMO's. He said:

"I don't believe the Administration's spokesmen and those of us who have associated with Prepaid Group Practice over the years have the same understanding of principles."

One of the principles that they believe in is:

" . . . the elimination of the fee system . . . accomplished through a salary arrangement. . . ." (See Group Practice and Prepayment of Medical Care, p. 20).

MEDICAL SOCIETIES BEING DECEIVED

Tragically, medical organizations are taking the bait of subsidies for Health Maintenance Organizations which are now being paid out by HW. So-called Medical Care Foundations are being organized by some Medical Societies ostensibly to outrun the labor union organizations in qualifying for HMO subsidies. Gerald Besson, M.D., consultant for HEW, and formerly President of the Santa Clara County (California) Medical Society, told the American Association of Medical Society Executives in New Orleans a couple of month ago that \$800,000 had been available in 1971 for "Experimental Medical Care Review Organizations" (EMCRO).

He added \$2 million would be available in fiscal 1972. He then said:

"If the private sector is to retain any measure of control over its destiny, it will have to be done by all taking the hard road. You execs have a key role to play in the months ahead. You have to inform your societies, get them to commit themselves to their new professional roles and show them exactly what needs doing.

However, Dr. Besson's encouraging the Medical Society executives to embrace HMO's doesn't square with what the labor union leaders are saying. The Group Health Association of America spokesman said in the hearings on S-1182:

"It would be a rather simple and tragic thing for a group of doctors to band themselves together, draw up a prepaid scheme, offer limited services labeled comprehensive, charge regular premiums, set excessively high fees, and call themselves a Health Maintenance Organization."

Obviously, labor union leaders have no intentions of allowing this to happen and with the HEW being sympathetic to union demands, it isn't apt to happen now or later. For example, GHAA said:

"There is always the possibility that a part time physician may favor his private practice patients over his prepaid enrolled *Health Maintenance Organization* patients. . . . Great care and constant vigilance is necessary to insure that the administrative and financial arrangements under which the physicians serve the HMO's . . . conduce to wholehearted fulfillment of this commitment, and that the arrangement in no way make possible—much less provide incentive—to discrimination against the Health Maintenance Organization membership."

Clearly doctors will be subservient to unionists and bureaucrat dominated HMO's or will stand by while such organization seduce their patients with public funds.

PREVENTIVE MEDICINE

HMO's are being sold on three other premises. That they will:

- (1) Prevent medical disorders;
- (2) Provide better and more care than is being provided, and
- (3) At lower costs

NO EVIDENCE

There is no evidence to support such claims.

First, preventive medicine is greatly oversold. The medical profession does not know how to prevent many disorders which constitute a high percentage of reasons that patients seek medical care. To mention only a few, accidents primarily with automobiles related to abuse of alcohol, asthma, arthritis, cardiovascular disease, diabetes, endometriosis, emphysema, gall bladder disease, malignant skin growths, marital problems, migraines, neurosis, slipped discs, etc. Man's health is threatened by drug abuse, smoking, physical indolence, obesity, and other disorders which go far beyond traditional services of physicians, dentists, etc. The primary responsibility for health maintenance belongs to the individual, and no trick of legislation can change this fundamental fact.

Second, the great advances in medicine are applicable to only a small percentage of patients. The vast majority of patients seeing doctors want help with the discomforts of a limited illness, or to learn how to deal with a chronic illness, or assurance from certain anxieties.

For most of these problems, the personal compassion of a trained physician remains the best medical care. Assembly-line medicine rationed by an HMO for maximum profit is not what he wants or needs.

The fundamental principle in medicine is "primum non nocere" (in the first place, do not harm). Others in society could do well by accepting such a basic principle.

Third, the cost of prepayment per capita group practice is expensive and will not lower costs. Kaiser-Permanente is often cited favorably as example of a

successful HMO. Yet, in the past few weeks, it was granted a 10.3% increase by the Price Commission, a percentage which was added to 3 prior increases for the immediately preceding 3 years for a total of 38%.

Serious questions are being raised as to advocating increased medical care in reducing disease, disability and death. The impact of medical care on health seems even less likely to be effective on the poor than on the average person, since the poor person's health will be more negatively influenced by poor sanitation, poor nutrition, inadequate housing and generally undesirable living conditions, regardless of any improvements in Medicare that might be available to him.

Seducing and driving patients and doctors into unionist and bureaucratically controlled collectives, burdening doctors with red tape, subjecting them to duress so that they shrink from doing their best for patients is wrong. This may gain temporary political power for the few, but it is a sure way of lowering medical care below where it would otherwise be.

Dr. Mark S. Blumberg, Corporate Planning Adviser to the Kaiser Health Foundation Plan, recently said:

"If we think national health insurance is going to wipe out the rich-poor gap as far as health is concerned, we are loading the system with an impossible goal."

Sidney R. Garfield, M.D., Director of the Kaiser Foundation, said:

"We believe the choice of alternative systems, including solo practice, is preferable for both the public and physicians. Any change to prepaid group practice should be evolutionary not revolutionary."

We submit that subsidizing one type over the other is revolutionary, unfair and not in the interests of patients or physicians

Passage of HR-1, as written, will:

Add to inflation;

Increase costs of medical care;

Provide federal funds to strengthen a labor union federal employee bureaucracy;

Discriminate against doctors caring for patients independently and in accordance with their best independent judgment;

Lower the quality of performance of the medical profession;

Deprive needy citizens of the best opportunity for improving their health.

The bill should be stripped of all subsidies and special privileges for per capita prepayment group practice.

PSRO

Pending Amendments to pay medical societies or medical foundations to become policemen for federal government medical programs should not be adopted.

INCOME WITHOUT WORK

(Administration's Family Assistance Plan)

We applaud the stand taken by Governor Reagan of California before this Committee in rejecting nationalization, and in insisting that welfare is a state and local responsibility which should not be pre-empted by or surrendered to the central government.

We encourage this Committee to live up to its constitutional responsibility to resist the bureaucracy.

The CHAIRMAN. Now, I am rather proud to present the witness for the Louisiana Medical Society, Dr. Edward M. Harrell. Dr. Harrell has impressive credentials and I would like to ask the reporter that his background be printed in the record at this point.

(The biography of Dr. Harrell follows:)

BIOGRAPHY OF EDWARD McLEOD HARRELL, M.D.

Born February 8, 1914

B.S. Degree, University of Georgia, Athens, Ga. 1935

M.D. Degree, Tulane University 1939

Internship Charity Hospital, New Orleans, La. 1939-1941

Residency, General Practice, H. P. Long Hospital, Aleandria, La. 1941-1942
 U.S. Army Medical Corps 1942-45. Discharged as Lt. Colonel.
 Residency, H. P. Long Charity Hospital 1945-46
 Organizing Board Member, Lafayette General Hospital, Lafayette, La.
 Chief of Medical Staff, Lafayette Hospital 1963
 President, Lafayette Parish Medical Society 1962
 President Louisiana Academy of General Practice 1964
 Member, House of Delegates 1955 to 1970 (Louisiana State Medical Society)
 Vice-President, Louisiana State Medical Society 1965-69
 Member, Southern Medical Association
 Private practice of Medicine, Lafayette Louisiana, 1946 to present.
 President, Louisiana State Medical Society, 1971-72

The CHAIRMAN. Doctor, we are pleased to have you and your associate here today.

STATEMENT OF EDWARD M. HARRELL, M.D., PRESIDENT, LOUISIANA STATE MEDICAL SOCIETY, ACCOMPANIED BY PAUL PERRET, ASSOCIATE SECRETARY-TREASURER, LSMS

Dr. HARRELL. Mr. Chairman and members of the committee, I am Edward M. Harrell, M.D., a family physician from Lafayette, La., and the President of the Louisiana Medical Society. I am a past president of the Louisiana Academy of General Practice, now known as the President of the Louisiana Medical Society. I am a past president of the Louisiana Academy of General Practice, now known as the Louisiana Academy of Family Practice.

Accompanying me is Mr. Paul Perret, Associate Secretary-Treasurer and Public Relations Director of the Louisian Medical Society.

Let me begin by thanking this committee for giving me the opportunity to present some of the views of the Louisiana State Medical Society on how medicare and medicaid programs can be improved and a number of sections of H.R. 1, the Social Security Amendments of 1972, that are of particular concern to the members of our society.

In 1970, the Louisiana State Medical Society presented a written statement to this committee on certain sections of H.R. 17550. Many of these sections are in H.R. 1 and there are also others that I would like to discuss with you today.

I will attempt to limit my remarks to those sections of H.R. 1 dealing with health and the physician's role and concern as the principal provider of health care. The Louisiana State Medical Society, through special committees, has carefully studied this bill, as well as the many others concerned with the various national health insurance proposals now before the Congress. The views that I express today will represent those of the overwhelming majority of our more than 3,300 physician members in Lousiana.

When I speak on the subject of peer review, peer review organizations, professional service review organizations, as provided for in the Bennett amendment, and catastrophic illness coverage, you may find that what I say is in conflict with positions taken by the American Medical Association. However, if you have ever attended a meeting of the Louisiana State Medical Society House of Delegates, or the American Medical Association House of Delegates, you will not find this unusual. As the chairman of the committee knows, groups in Louisiana, while for the most part go along with their national organiza-

tions, reserve the right to present different views and proposals when they feel they are right although they might even represent a minority viewpoint. No one has ever accused our society of being a silent majority.

The first item——

The CHAIRMAN. If I ever accused you of that, I take it back. [Laughter.]

Dr. HARRELL. The first paragraph which I would like to discuss concerns the Health Maintenance Organizations, section 226.

The Louisiana State Medical Society believes that competition is good amongst the legitimate providers of health care and that there is nothing wrong with health maintenance organizations that are ethically operated within the framework of the competitive marketplace.

However, H.R. 1 strongly endorses HMO's and provides Federal economic incentives for their operation.

The HMO concept has existed for years as witnessed by the various Kaiser plans, the HIP plan in New York and the Stanocola plan in Baton Rouge, La.; and that, incidentally, has existed since 1928, and for specifically the employees of the Standard Oil Co. in this area.

The fact that these plans have not grown at the same rate as private insurance plans or the Blue Cross/Blue Shield plans indicates public reluctance to accept them. The old adage that "if you build a better mousetrap, people will beat a path to your door" holds true also for systems of delivering health care. This has not proven to be the case in Louisiana where it has become necessary for the Stanocola plan to extend the eligibility requirements for participation in the plan to the married children and even grandchildren of those who were originally eligible in order to get enough people in the plan to make it actuarially sound, which should be in the area, I am told, of about 30,000 participants.

The proponents of HMO's argue that by virtue of their contractual assumption of the responsibility for a defined range of services at a negotiated per capita rate allows them wide latitude, subject to legislation and regulations, in making their own professional decisions, establishing priorities for patient care and exercising self-discipline to assure the adequacy and quality of services provided.

While no one will argue with the concept of "better for less," the proponents of HMO's fail to point out that any program of health care must be based on fiscal soundness. A fixed-price contract for services and the amount of services that cannot be fully predicted could possibly result in the type of cost cutting that would be to the disadvantage of the patient.

The Louisiana State Medical Society must regard the HMO concept as only one experimental plan to encourage innovation in the organization and delivery of health care services. The Louisiana State Medical Society strongly favors innovations providing high quality medical care at reasonable cost for all segments of the population; however, this must be within the framework of the competitive marketplace with no system receiving Federal subsidies that would discriminate against the private, fee-for-service concept for the delivery of home care.

For the information of the committee, I am attaching as exhibit A to my testimony a special issue of "Capsules," the Louisiana State Medi-

cal Society newsletter, published in June of 1971, outlining our views in greater depth on health maintenance organizations.

The next paragraph which I would like to discuss is section 224, Limits on prevailing charges.

Senator CURTIS. May I ask you before that, are you supporting peer review?

Dr. HARRELL. We are doing peer review.

Senator CURTIS. Are you supporting it in the Bennett amendment in this bill?

Dr. HARRELL. No, sir, we are not supporting it because it does not come in this category. We strongly, as I will mention later, we strongly oppose the Bennett amendment and our house of delegates has discussed this at length at a special meeting called to discuss this particular element. They have voted almost unanimously not to support the Bennett amendment or the pro section of the medicredit bill, which also is contrary to the AMA policy.

Limits on prevailing charge levels—this is a statement here which I am sure you are familiar with; it is academic since it has been implemented by the Bureau of Health Insurance so I will go rapidly over that since the hour is late. I would like this submitted for the record of the committee.

We also stated in our previous statement to the Finance Committee that if Congress in its wisdom determines that this Nation should have overall wage and price controls, the medical profession would gladly concur that an increase in customary charges prevailing in a locality should be tied to the cost-of-living index.

Gentlemen, I point this out for two reasons: First, it is not always the laws enacted by the Congress that give us the most trouble but the regulations issued to implement the laws. If, by regulation, one section of an unpassed law can be fully implemented, then is it not possible that the same could be done for other sections of the law without the approval of the Congress?

The second point I would like to make here is that the medical profession was subject to the same discrimination in the phase II economic guidelines issued by the Price Commission. These regulations limited physicians to a 2.5 percent increase factor when other professions were left unregulated and just about everyone else was given a 5.3 percent or higher margin to work with. While medicine is a profession and must always remain a profession, it is governed by the same fundamental economic laws as business. All we ask is that we be afforded equal treatment and not be singled out for special treatment because of the nature of our profession.

I will go to amendment No. 823 to H.R. 1 and discuss in detail this item.

Senator Bennett has proposed an amendment No. 823 to H.R. 1 that is quite similar to the amendment he proposed to H.R. 17550, calling for the establishment of professional standards review organizations. In addition, several representatives have introduced similar legislation; and I am sure you are familiar with the goal of this particular legislation so I will pass that.

We do oppose the Bennett amendment.

The Louisiana State Medical Society shares the concern of Senator Bennett and other Congressmen with the quality and cost of health

care. We fully support internal peer review as is now being done by our hospital tissue committees, utilization review committees, other hospital committees and local and State medical societies. This is quality peer review at no cost to the consumer. However, the Bennett amendment to H.R. 1 as we read it is concerned with review for economic purposes. There is no question that proposals such as this are intended to put the brakes on spiraling health care costs and, if passed, would make the doctors the scapegoats.

There are other reasons why we are concerned about the various PSRO and PRO proposals. Perhaps foremost is the issue of confidentiality of medical records. This has become quite an issue in our society and we believe that if any national review program be adopted by the Congress we have no doubt that medical records would no longer be confidential. We can state this with authority because medicare through its fiscal intermediary Blue Cross, is already demanding entire medical records for review, before paying claims, entire photostatic records, even when there is not the slightest hint of any irregularities in treatment or suspicion of fraud.

To protest this intrusion on the innermost privacy of our patients, the Louisiana State Medical Society introduced a resolution at the clinical convention of the American Medical Association in New Orleans in November 1971, condemning this practice. Our society believes that all the information any insurance company or Government agency needs to pay a claim is the information contained on the face sheet of the hospital record and this is more or less a summary and at times a brief narrative summary of the case. There is no need whatsoever to make available to third parties progress notes, personal observations, et cetera, of the physician and nurses because these may contain information that should not be made known to his insurer or anyone else, except the patient or his family. The patients who are aware of this consider it an invasion of their privacy and perhaps their rights.

A copy of the Louisiana State Medical Society resolution on this subject that was presented to the AMA is attached as exhibit C.

The Louisiana State Medical Society tried to assist one of our small hospitals, one in particular, a small hospital, St. Joseph Hospital in Thibodaux, La., that refused to release their records and almost was forced out of business. This was a small hospital operated by the Catholic sisters and a small amount of money, \$65,000 and to this hospital it represented quite a bit; and Blue Cross demanded an entire photocopy of the records and when it came to a showdown they withdrew medical support and in the end the sisters had to furnish the records, under protest, or not receive the funds which they had already earned, so to speak.

There was no question of fraud or improper treatment or any legal question involved in this instance.

Not only small hospitals but some of the large hospitals also have had problems and I attach hereto a letter from the Ochsner Foundation Hospital dated January 19, 1972, addressed to Mr. Durel Russell, Blue Cross, New Orleans, and it goes into great detail about the problems this hospital, which is one of the very fine institutions and has

tried to conform to the letter and the spirit of the law, and they have had no end of problems.

This is attached for your information.

The thing that no PSRO or PRO or similar peer review organization can ever do is draw the fine line between the science of medicine and the art of medicine. There is no way that a computer or clerk can take into account that each person is different, each illness is different and the individual professional judgment of the physician must apply to each case.

As I have said before, we do not object to true peer review if it is for the purpose of improving the quality of care. There are already sufficient laws on the books to protect the Government against fraudulent acts by physicians and other providers of health care.

There is a section concerning the tax study on physicians' returns and, I might add, that the summary of the Internal Revenue Service was 99 percent of the actual receipts were correctly reported, just to summarize briefly.

Gentlemen, the point I am trying to make is that PSRO and PRO organizations are not going to save the Government or the consumer from spending unnecessarily on medical care. In the long run, they will only add to the cost of medical care and, incidentally, I have tried to find Senator Bennett's recommendation of the cost of implementing his amendment and nowhere have I read estimates of the costs to the consumer of this particular amendment.

The CHAIRMAN. I can give you that right now: The estimated cost is \$60 million.

Dr. HARRELL. \$60 million. I have not run across that figure. Sixty million dollars.

The present PRO and PSRO proposals call for these programs to be administered by contracts with State medical associations. The members of our society are so opposed to such an arrangement that the Louisiana State Medical Society House of Delegates passed a resolution prohibiting our society from entering into any contractual arrangements with the Federal Government for this or any other purpose, and that was the end as far as this particular item was concerned.

Section 229, the authority of the Secretary to terminate payments to suppliers of services—the Louisiana State Medical Society again protests the inclusion of this section in the bill. It would give the Secretary of HEW the authority to appoint one or more "program review teams" in each State to be composed of groups representing consumers of health services, State and local professional societies, intermediaries and carriers utilized in the administration of title XVIII benefits.

We fully agree that the Secretary should have the authority to terminate payment to suppliers of services for fraud, false statements, and misrepresentation of any material fact used in making application for payment. However, we strongly feel that program review teams, because of their composition, would not be in a position to make valid medical judgments. In addition, it is questionable that the cost of maintaining and supporting such an operation would come anywhere near what might be saved. We firmly believe the systems presently available and in operation in our hospitals are adequate to satisfy the intent of this section of H.R. 1.

SECTION 273, THE CHIROPRACTIC STUDY

H.R. 1 calls for another study of including the services performed by chiropractors in title XIX and the extent of their services that should be allowed under part B of title XVIII. As you will recall, there was a very detailed in-depth study in 1968, I believe, when Mr. Wilbur J. Cohen was Secretary of HEW, and the summary of that 2-year study by a blue ribbon panel stated that chiropractic theory and practice are not based upon the body of scientific knowledge related to health and, briefly, they recommended that the chiropractic services not be covered in medicare; and we believe this is just as valid today as it was in 1968.

PAYMENTS TO PATIENTS UNDER MEDICAID, TITLE XIX

To summarize this, I know the hour is late and the time is short—we request the same billing options for title XIX patients as we do and have been given for title XVIII patients.

The list item that I would like to discuss is the catastrophic illness amendment.

As I mentioned in my earlier remarks, our society has devoted considerable time to studying the various national health insurance proposals now before the Congress wherein we accepted Chairman Long's invitation to appear before your committee; he had not yet introduced catastrophic illness insurance amendment to H.R. 1, though it has been widely reported in the press that he intended to do so. Because of this, we welcome an opportunity to make some general comments on this amendment based on our study of his previous catastrophic illness insurance bill.

The CHAIRMAN. Doctor, my catastrophic proposal has been introduced in a bill, S. 1376.

Dr. HARRELL. Introduced in 1971, yes. Is that the one?

The CHAIRMAN. Yes.

Dr. HARRELL. We have that in great detail and I would like to elaborate on that.

The CHAIRMAN. Thank you.

Dr. HARRELL. I believe in considering plans of this type we should assess first is there a genuine need; second, can the need be fulfilled with presently available health manpower and resources. That is very important as to cost.

There is no doubt in my mind that catastrophic illness insurance should be made available to all people regardless of their past health history. All but the very wealthy can be bankrupted by a catastrophic illness. Of course, the term could perhaps be redefined—I mean, what might be catastrophic to me may not be catastrophic to someone else. It is only fair that a person who has worked hard and tried to save a little for his old age should not have to live with the fear of losing everything because he or a member of his family is struck with a catastrophic illness. Therefore, I believe a genuine need exists for this coverage; there is a need for this type of coverage.

Because many people now have catastrophic illnesses and are being cared for, the universal availability of catastrophic illness insurance

should not place any great new demand on manpower but as far as the hospital facilities and the nursing home facilities that is another question that perhaps it would throw an additional load on these if it were financed by the Federal program.

I don't think we can expect any abuse from the consumer on this particular thing because they do all they can to prevent this particular type of illness.

Physicians do not claim to be experts on cost of governmental programs. When the great medicare debate was going on a few years ago, the AMA estimated it would cost twice as much as its backers said it would. Of course, physicians were accused of using scare tactics and, as it turned out, most of you who are familiar with the program realize it costs considerably more than was estimated and just about what the AMA estimates projected.

I have a summary of the cost of the various health programs and I will round those out to the nearest \$1 billion since they are estimated:

The Kennedy plan, \$59 billion. I suspect it might cost considerably more than that.

The Javits bill, \$41 billion; health insurance industry, \$7 billion; AMA Mediredit, \$6 billion; Pell-Mondale, \$4 billion; and the Long catastrophic amendment, \$3 billion; the Nixon administration bill, \$2 billion 600 million.

Assuming that the costs will be considerably more than projected, these are items that we should consider; cost items are an important item and without proper planning of these programs, a coordination of effort, we could possibly end up with a less satisfactory health care system than we have at the present.

One of the things the Louisiana State Medical Society did in studying the various national health insurance proposals was to draw up a group of basic criteria which I have listed in detail: (1) There should be established a basic combination major medical and catastrophic insurance policy; (2) this policy should be sold by the private insurance companies of America and purchasable by individuals on a voluntary basis; (3) this policy should be available to all citizens regardless of prior health history and should be noncancellable and guaranteed renewable; (4) this policy should have coordination of benefits, coinsurance and deductible features; (5) this policy should provide benefits for both inpatient and outpatient care; (6) there should be established a health insurance committee composed primarily of professional health insurance actuaries and practicing physicians to determine or formulate the scope of the benefits, the schedule, the schedule of benefits and the coinsurance and deductible features and this in no way implies a fixed-fee schedule; (7) premium costs should be paid by the Federal Government in total for the poor and in part for low-income groups; (8) an identifiable, visible tax should be imposed by the Federal Government to cover its premium payment costs; (9) all coinsurance, deductibles and costs in excess of benefits should be borne by the insured; (10) in order to protect the quality of medical care in this Nation, the act must specifically provide, and we list a number of freedoms. One is the freedom of patients to choose his physician which is elementary but not always present in some of these plans.

It also provides that the physician should be able to decide whom he will treat, what particular types of illness he will treat, except in emergencies.

Freedom of the physician to choose the method of treatment of his patients consistent with good medical practice in his locality.

Freedom of the physician to practice in the geographic location of his choice. This, we think, is basic to our American free choice of where you want to live and practice and work.

Freedom of the physician to admit his patients to a hospital for treatment under the continuing concept that this is the sole prerogative of the physician, consistent with the official policy of the hospital medical staff and irrespective of race, creed, color, or political belief.

Freedom of the physician to have the right of direct billing, the right to determine the method of receiving payment by which he would prefer to be paid. Fee for service, we think, should be preserved because that is probably the least expensive and most satisfactory to all patients concerned.

I believe you can see from the foregoing that the chairman's proposal for a catastrophic insurance plan meets many of these criteria. Our society, I am sure, would be happy to work with Senator Long and others in drawing up a plan incorporating these standards.

Mr. Chairman and members of the committee, please let me thank you again in behalf of the members of the Louisiana State Medical Society for giving us the opportunity to testify on this important legislation. We will be happy to attempt to answer any questions which you have.

The CHAIRMAN. Thank you very much, Dr. Harrell; you have made a very fine statement.

I think it would help to further enlighten the committee and the Senate generally toward some of the problems that are involved in HMO as compared to the fee-for-service approach if we had available to us a paper that was prepared by one of the doctors at Ochsner—maybe it is the same Dr. Riddick to whom you make reference here?

Dr. HARRELL. Yes.

The CHAIRMAN. I read his paper some time ago and it was a very good paper.*

Dr. HARRELL. I have exhibit A, an issue of "Capsules," dated January 1971, which gives the details of our society's position in HMO's and it is attached to my testimony; and I would like to have the entire testimony included in the record.

The CHAIRMAN. Yes. We will do that.

(The prepared statement and attachments of Dr. Harrell follow. Hearing continues on p. 2683.)

PREPARED STATEMENT OF EDWARD M. HARRELL, M.D., LOUISIANA STATE MEDICAL SOCIETY

Mr. Chairman and members of the committee, I am Edward M. Harrell, M.D., a family physician from Lafayette, Louisiana, and president of the Louisiana State Medical Society. I am past-president of the Louisiana Academy of General Practice, now known as the Louisiana Academy of Family Practice. Accompanying me is Mr. Paul Perret, Associate Secretary-Treasurer and Public Relations Director of the Louisiana State Medical Society.

*See p. 2673.

Let me begin by thanking this committee for giving us an opportunity to present some of the views of the Louisiana State Medical Society on how the Medicare and Medicaid programs can be improved and a number of sections of H.R. 1, the social security amendments of 1972, that are of particular concern to the members of our society.

In 1970 the Louisiana State Medical Society presented a written statement to this committee on certain sections of H.R. 17550. Many of these sections are in H.R. 1 and there are also others that I would like to discuss with you today.

I will attempt to limit my remarks to those sections of H.R. 1 dealing with health and the physician's role and concern as the principal provider of health care. The Louisiana State Medical Society, through special committees, has carefully studied this bill, as well as the many others concerned with the various national health insurance proposals now before the Congress. The views that I express today will represent those of the overwhelming majority of our more than 3,300 physician members.

When I speak on the subject of peer review, peer review organizations, professional service review organizations, as provided for in the Bennett Amendment, and catastrophic illness coverage, you may find that what I say is in conflict with positions taken by the American Medical Association. However, if you have ever attended a meeting of the Louisiana State Medical Society House of Delegates, or the American Medical Association house of delegates, you will not find this unusual. As the chairman of this committee knows, groups in Louisiana, while for the most part go along with their national organizations, reserve the right to present different views and proposals when they feel they are right although they might even represent a minority viewpoint. No one has ever accused our society of being a "silent minority".

HEALTH MAINTENANCE ORGANIZATIONS (SEC. 226)

The Louisiana State Medical Society believes that competition is good amongst the legitimate providers of health care and that there is nothing wrong with health maintenance organizations that are ethically operated within the framework of the competitive marketplace.

However, H.R. 1 strongly endorses HMOs and provides federal economic incentives for their operation. In addition, the administration, Senator Edward Kennedy and others are all proposing HMO legislation calling for heavy financial support from the Federal Government.

The HMO concept has existed for years as witnessed by the various Kaiser plans, the HIP plan in New York and the Stanocola plan in Baton Rouge, Louisiana, one of the oldest health maintenance organizations in the United States. The fact that these plans have not grown at the same rate as private insurance plans or the Blue Cross-Blue Shield plans indicates public reluctance to accept them. The old adage that "if you build a better mouse trap, people will beat a path to your door" holds true also for systems of delivering health care delivery. This has not proven to be the case in Louisiana where it has become necessary for the Stanocola Plan to extend the eligibility requirements for participation in the plan to the married children and even grandchildren of those who were originally eligible in order to get enough people in the plan to make it actuarially sound.

The proponents of HMOs argue that by virtue of their contractual assumption of the responsibility for a defined range of services at a negotiated per capita rate allows them wide latitude—subject to legislation and regulations—in making their own professional decisions, establishing priorities for patient care and exercising self-discipline to assure the adequacy and quality of services provided.

While no one will argue with the concept of "better for less", the proponents of HMOs fail to point out that any program of health care must be based on fiscal soundness. A fixed price contract for services that cannot be fully predicted could result in the type of cost cutting that would be to the disadvantage of the patient.

The Louisiana State Medical Society must regard the HMO concept as only one experimental plan to encourage innovation in the organization and delivery of health care services. The Louisiana State Medical Society strongly favors innovations providing high quality medical care at reasonable costs for all segments of the population. However, this must be within the framework of the competitive marketplace with no system receiving federal subsidies that would discriminate against the private, fee-for-service concept for the delivery of health care.

For the information of the committee, I am attaching as exhibit "A" to my testimony a special issue of *Capsules*, the Louisiana State Medical Society

newsletter, published in June of 1971 outlining our views in greater depth on health maintenance organizations.

LIMITS ON PREVAILING CHARGE LEVELS (SEC. 224)

In the statement submitted by the Louisiana State Medical Society to Committee on Finance of the Senate in September 1970 on H.R. 17550 we strongly protested this section of the bill. It provided that for physician services rendered after July 30, 1970, and before July 1, 1971, a "reasonable" charge could not exceed the higher of: (A) the prevailing charge level existing in June 30, 1970; or (B) the prevailing charge level covering 75% of the customary charges made for similar services in the same locality during the calendar year 1969. For services rendered after June 30, 1971, the prevailing charge levels could only be increased above the 1969 levels to the extent permitted by the secretary on the basis of appropriate economic index data.

While H.R. 17550 was never passed by the Congress, the Bureau of Health Insurance of the Social Security Administration implemented this section of the bill through administrative procedures.

We said two years ago that such an amendment was grossly discriminatory in that "it singles out one profession and, in effect, establishes price controls over the profession by the Federal Government."

We also said then that "if the Congress, in its wisdom determines that this nation should have overall wage and price controls, the medical profession would gladly concur that an increase in customary charges prevailing in a locality should be tied to the cost of living index."

Gentlemen, I point this out for two reasons. First, it is not always the laws enacted by the Congress that give us the most trouble, but the regulations issued to implement the laws. If, by regulation, one section of an unpassed law can be fully implemented, then, is it not possible that the same could be done for other sections of the law without the approval of the Congress?

The second point I would like to make here is that the medical profession was subject to the same discrimination in the Phase II economic guidelines issued by the Price Commission. These regulations limited physicians to a 2.5% increase factor when other professions were left unregulated and just about everyone else was given a 5.5% or higher margin to work with. While medicine is a profession and must always remain a profession, it is governed by the same fundamental economic laws as business. All we ask is that we be afforded equal treatment and not be singled out for special treatment because of the nature of our profession.

Since section 224 has already been passed by regulatory edict, we can only reaffirm our opposition to it and ask that you be ever mindful of the rule makers who appear to us to be becoming lawmakers. Attached as exhibit "B"—Federal Register, Vol. 35, No. 235—Thursday, December 31, 1970, is the regulation issued on this subject.

AMENDMENT NO. 823 TO H.R. 1

Senator Bennett has proposed an amendment (No. 823) to H.R. 1 that is quite similar to the amendment he proposed to H.R. 17550 calling for the establishment of professional standards review organizations. In addition, several representatives have introduced similar legislation including a peer review organization proposal that has the endorsement of the American Medical Association.

The stated intent of the Bennett amendment is to promote effective, efficient and economical delivery of health services for which payment may be made under the Social Security Act through the employment of professional standards review organizations. These organizations are also to determine that the services performed are of appropriate quality, are provided only when necessary, and in the most economical manner consistent with recognized professional health care standards.

The Louisiana State Medical Society shares the concern of Senator Bennett and other Congressmen with the quality and cost of health care. We fully support internal peer review as is now being done by our hospital tissue committees, utilization review committees, other hospital committees and local and state medical societies. This is quality peer review. However, the Bennett amendment to H.R. 1, as we read it, is concerned with review for economic purposes. There is no question that proposals such as this are intended to put the brakes on

spiraling health care costs and, if passed, would make the doctors the scape goats.

There are other reasons why we are concerned about the various pro and pro proposals. Perhaps foremost is the issue of confidentiality of medical records. Should any national review program be adopted by the Congress, we have no doubt that confidential medical records would no longer be confidential. We can say this with authority because medicare through its fiscal intermediary, Blue Cross, is already demanding entire medical records for review, before paying claims, even when there is not the slightest hint of any irregularities in treatment or suspicion of fraud.

To protest this intrusion on the innermost privacy of our patients, the Louisiana State Medical Society introduced a resolution at the clinical convention of the American Medical Association in New Orleans in November 1971 condemning this practice. Our society believes that all the information any insurance company or government agency needs to pay a claim is the information contained on the "face sheet" of the hospital record and/or perhaps, at times, a brief narrative summary of the case. There is no need whatsoever to make available to third parties progress notes, personal observations, etc. of the physician and nurses because these may contain information that should not be made known to his insurer or anyone else, except the patient or his family. A copy of the Louisiana State Medical Society resolution on this subject that was presented to the AMA is attached as Exhibit "C".

The Louisiana State Medical Society tried to assist one of our small hospitals, St. Joseph Hospital, in Thibodaux, Louisiana, that refused to release entire medical records on medicare patients to Blue Cross, the fiscal intermediary for part A. Blue Cross informed the hospital that it would not pay for medicare services until the records were released. The hospital held out as long as it could, but it was a small hospital and the amount of money involved was \$65,000. In the end, the hospital had no choice but to release, under protest, the records requested or go out of business. Interestingly enough, there was no question of fraud, improper treatment or any legal question involved in this instance.

Not only small rural hospitals have had problems with review procedures, but also some of our larger and best known institutions. I believe the following letter will give you some idea of the problem physicians are having in another area of medicare review although the physicians and management of this hospital are doing everything possible to comply with the letter and the spirit of the law.

OCHSNER FOUNDATION HOSPITAL,

January 19, 1972.

Mr. DUREL RUSSELL,
Blue Cross, New Orleans, La.

DEAR MR. RUSSELL: I have written you several times recently in conjunction with my duties as chairman of the utilization review committee of Ochsner Foundation Hospital. I now write to request clarification of some of the procedures used in processing of hospital claims for Medicare patients by Blue Cross.

I would be less than honest not to tell you that I am troubled by the fact that your review process apparently operates in a vacuum insofar as the medical profession is concerned. I have seen little evidence that responsible medical advice is sought when you make medical decisions in judging the necessity for medical care. I do not refer to decisions as to whether a service is covered or not, such as cosmetic surgery or dental work. I will not refer to cases in which you decide that the patient needed only eight days in the hospital instead of ten, although I would like to learn at some future date how you reach such decisions. I refer specifically to cases in which you question the medical necessity for hospitalization and at times decide that hospital care was unnecessary for management of the patient. I firmly believe this to be a medical decision, requiring professional judgment.

Until recently, your review process has bypassed the physician. Blue Cross would request the hospital administrator to submit portions of the hospital record for study in questioned cases. If the claim was disallowed, Blue Cross notified the hospital administrator, who in turn billed the patient for the disallowed sum. If the patient complained, he was referred to Blue Cross and if the patient requested review, the records were submitted to Baltimore for review by the Department of Health, Education and Welfare. Unless the patient

or hospital administrator notified the attending physician he was ignorant that the claim was disallowed.

Recently, the initial request has come to the hospital administrator to submit evidence to support the necessity for hospitalization. This involves the attending physician in many hospitals, as he is asked to supply this information in narrative form, but in others the record is still submitted. If the documentation of need for hospitalization is judged to be questionable, the hospital administrator is requested to submit selected portions of the record. As near as I can tell, the procedure from this point on is as listed above.

Since the hospital maintains a peer review group in its utilization review committee and since the local medical society has a peer review committee, it is unfortunate that you fail to consult these groups to help you in assessing the appropriateness of medical care.

The questions which I have and to which I would appreciate an answer are:

1. Who reviews medicare claims at Blue Cross?
2. At what level does a medical consultant operate?
3. What criteria are employed to decide which cases required further investigation beyond the initial claim form?
4. When a response is received to a request for evidence for the necessity for hospitalization, what criteria are employed and by whom to decide if further documentation is required?
5. When such documentation is received, what criteria are employed and by whom to decide if hospital care was or was not necessary?
6. When peer review or cases in question or cases which have been rejected is undertaken by the hospital's utilization review committee and a contrary decision reached by the committee, what is the mechanism of appeal and to whom? Is the appeal evaluated by a local group or is this sent to HEW in Baltimore?
7. In case the hospital's utilization review committee and the local carrier (or HEW, if there is no local review) are in disagreement on a given case is a response sent to the committee so that an appeal may be made to the medical society peer review committee?
8. What status will the response of the medical society peer review committee be given and by whom?
9. At what juncture can the patient or the hospital seek judicial relief?

At the recent meeting of the American Medical Association in New Orleans, the following resolution was adopted by the House of Delegates in response to a request from the Louisiana State Medical Society:

Resolved, That the American Medical Association urge all health insurance carriers and Government health financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning the quality, cost or utilization of medical services which require professional judgment: and be it further

Resolved, That the American Medical Association reaffirm that it is the responsibility of State medical associations, county medical societies, and hospital medical staffs to create active and effective systems of peer review which are responsive to the needs of their respective communities; and be it further

Resolved, That peer review programs shall have as their goal both improved quality of medical care and more efficient delivery of medical services.

We at Ochsner Foundation Hospital have always attempted to work in harmony and cooperation with Blue Cross and other health insurers. We believe that our utilization review committee has functioned effectively and fairly. You will recall that previous communications from our committee have requested a review of only those disallowed cases which the committee after thorough study believed were justified.

I would appreciate an answer to my questions; I will be happy to schedule a meeting with you to discuss these problems.

Sincerely,

FRANK A. RIDDICK, Jr., M.D.,
Chairman, Utilization Review Committee.

The thing that no PSRO, pro or similar review organization can ever do is to draw the fine line between the science of medicine and the art of medicine. There is no way that a computer or clerk can take into account that each person

is different, each illness is different and the individual professional judgment of the physician must apply to each case.

As I have said before, we do not object to true peer review if it is for the purpose of improving the quality of care. There are already sufficient laws on the books to protect the government against fraudulent acts by physicians and other providers of health care.

In May of 1971, I believe upon the recommendation of this committee, the IRS completed a study of tax returns filed by physicians, dentists and other health care providers who received \$25,000 or more during 1968 under medicare and medicaid. In a press release, the IRS said 83% of *all providers* reported their receipts correctly. Of those who had mistakes on their returns, 15% underreported receipts by an average of \$7,700 and 2% overreported by an average of \$16,000. Overall, the IRS said, 99% of actual receipts and 97% of net profits were correctly reported. In a later release, the IRS said that 47 cases had been referred to its intelligence division for preliminary or full-scale fraud investigation. Presuming that all 47 of these people, and we believe this number includes not only physicians, but osteopaths, dentists and other providers, were guilty of fraud, the percentage of physicians and the dollar amount involved would be so small that the investigation in all probability cost several times what the government recovered. This is a laudable record for any group.

Gentlemen, the point I am trying to make is that PSRO and PRO organizations are not going to save the government or the consumer from spending unnecessary on medical care. In the long run, they will only add to the cost of medical care even though I am sure the sponsors of such legislation have already received glowing reports to the opposite from a few small areas where organizations of this type are already in operation.

Present PRO and PSRO proposals call for these programs to be administered by contracts with State Medical Associations. The members of our society are so opposed to such an arrangement that the Louisiana State Medical Society House of Delegates passed a resolution prohibiting our society from entering into any contractual arrangements with the Federal Government for this or any other purpose.

AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES (SEC. 922)

The Louisiana State Medical Society again protests the inclusion of this section in the bill. It would give the Secretary of HEW the authority to appoint one or more "Program Review Teams" in each State to be composed of groups representing consumers of health services, State and local professional societies, intermediaries and carriers utilized in the Administration of Title XVIII benefits.

We fully agree that the secretary should have the authority to terminate payment to suppliers of services for fraud, false statements and misrepresentation of any material fact used in making application for payment. However, we strongly feel that "Program Review Teams", because of their composition, would not be in a position to make valid medical judgments. In addition, it is questionable that the cost of maintaining and supporting such an operation would come anywhere near what might be saved. We firmly believe the system presently available and in operation are adequate to satisfy the intent of this section of H.R. 1.

CHIROPRACTIC STUDY (SEC. 273)

H.R. 1 calls for another study of including the services performed by chiropractors in title XIX and the extent of their services that should be allowed under part B of title XVIII. The 90th Congress in P.L. 90-248, the social security amendments of 1967, directed the then Secretary of HEW, Wilbur J. Cohen, to make such a study and make a report to the Congress on this subject.

Mr. Cohen assembled a blue ribbon, impartial group of experts to assist in preparing an indepth report of chiropractic. The conclusion of that study was that no changes be made in medicare relative to the services of chiropractors. This report and its recommendations remain valid. To undertake any further study of the inclusion of chiropractic services in medicare would be a gross waste of the taxpayers money.

PAYMENTS TO PATIENTS UNDER MEDICAID (TITLE XIX)

On August 30, 1967 one of Louisiana's great physicians and medical statesmen, the late Philip H. Jones, M.D., had the honor to appear before this committee to testify on the social security amendments of 1967 (H.R. 12080) in behalf of the Louisiana State Medical Society.

Dr. Jones made a strong plea to amend the law to allow physicians the same billing options for their title XIX patients as those permitted for their more affluent title XVIII patients as a method of helping to preserve the traditional patient-physician relationship.

We were very happy when the law was amended to allow this for medicaid recipients except those receiving cash assistance from the States. We have tried on many occasions to have the Louisiana Department of Public Welfare to change their regulations to give the allowed direct billing option to those physicians not wishing to accept assigned payments from their title XIX patients.

As Dr. Jones said more than five years ago, physicians would probably lose money by using such a billing system because the state would reimburse the patient for physicians' services and some patients might use the money for other purposes and not pay the doctor. As a matter of principle, he said "physicians would prefer to suffer whatever financial loss might be involved in direct billing in order to protect and preserve the patient-physician relationship."

Gentlemen, the only reason I bring this matter up again is that I hope there is some way your committee can help us get the States to do what the law makes provision for in this matter.

CATASTROPHIC ILLNESS AMENDMENT

As I mentioned in my earlier remarks, our society has devoted considerable time to studying the various national health insurance proposals now before the Congress. When we accepted Chairman Long's invitation to appear before your committee, he had not yet introduced his catastrophic illness insurance amendment to H.R. 1, though it has been widely reported in the press that he intended to do so. Because of this we welcome an opportunity to make some general comments on this amendment based on our study of his previous catastrophic illness insurance bill. We understand it is similar to S. 1376 introduced in 1971.

I believe in considering plans such as this we should assess whether there is first, a genuine need; second, can the need be fulfilled with presently available health manpower and resources; and third, the cost.

There is no doubt in my mind that catastrophic illness insurance should be made available to all people regardless of their past health history. All but the very wealthy can be bankrupted by a catastrophic illness and the poor because they have already been wiped out. A person who has worked hard and tried to save a little for his old age should not have to live with the fear of losing everything because he, or a member of his family, is struck with a catastrophic illness. Therefore, I believe there is a genuine need for this type coverage.

Because people presently have catastrophic illnesses and are being cared for, the universal availability of catastrophic illness insurance should not place any great new demand on manpower, although it might on health care facilities. This is the one form of insurance where there should be no abuse from the consumer as I cannot picture any sane person doing anything, except doing his best to prevent himself from becoming the victim of such an illness.

Physicians do not claim to be experts on the cost of government programs. When the great medicare debate was going on a few years ago, the AMA estimated it would cost twice as much as its backers said it would. Of course, physicians were accused of using scare tactics, to say the least. After a few years experience with medicare it turned out that the AMA's cost estimates were just about 100% accurate. It did no good to tell the Congress, or the public, "we told you so"! With this experience in mind, I will discuss costs very cautiously.

I recently read the following estimates on what the various national health insurance proposals now before the Congress would cost:

	Millions
Kennedy -----	\$59, 400
Javits (medicare for all) -----	41, 600
Health insurance industry -----	7, 300
AMA Mediredit -----	6, 300
Pell-Mondale -----	4, 900
Long (catastrophic only) -----	3, 200
Nixon administration -----	2, 600

Assuming that history will repeat itself, the catastrophic illness insurance amendment certainly appears as one of the most attractive offered from the view of cost. If the figures for Senator Edward Kennedy's proposal were doubled, I believe the program would bankrupt the Federal Government.

One of the things the Louisiana State Medical Society did in studying the various national health insurance proposals was to draw up what might be called, basic criteria that should be a part of any national health insurance program. These are as follows:

1. There should be established a basic combination major medical and catastrophic insurance policy.

2. This policy should be sold by the private insurance companies of America and purchasable by individuals on a voluntary basis.

3. This policy should be available to all citizens regardless of prior health history and should be non-cancellable and guaranteed renewable.

4. This policy should have coordination of benefits, co-insurance, and deductible features.

5. This policy should provide benefits for both in-patient and out-patient care.

6. There should be established a health insurance committee composed primarily of professional health insurance actuaries and practicing physicians. This committee would annually formulate the scope of benefits, a schedule of benefits, and the co-insurance and deductible features. This in no way implies a fixed fee schedule.

7. Premium costs should be paid by the Federal Government in total for the poor and in part for low income groups.

8. An identifiable, visible tax should be imposed by the Federal Government to cover its premium payment costs.

9. All co-insurance, deductibles, and costs in excess of benefits should be borne by the insured..

10. In order to protect the quality of medical care in this Nation, the act must specifically provide:

- (a) Freedom of the patient to choose his physician.

- (b) Freedom of the physician to decide whom he will treat, except in emergencies.

- (c) Freedom of the physician to choose the method of treatment of his patients consistent with good medical practice in his locality.

- (d) Freedom of the physician to practice in the geographic location of his choice.

- (e) Freedom of the physician to admit his patient to a hospital for treatment under the continuing concept that this is the sole prerogative of the physician, consistent with the official policy of the hospital medical staff, and irrespective of race, creed, color or political belief.

- (f) Freedom of the physician to have the right of direct billing, the right to determine the method of receiving payment for his service, and the right to a fee-for-service concept in the delivery of medical care.

I believe you can see from the foregoing that the Chairman's proposal for a catastrophic insurance plan meets many of these criteria. Our society, I am sure, would be happy to work with Senator Long and others in drawing up a plan incorporating these standards.

Mr. Chairman and members of the committee, please let me thank you again in behalf of the members of the Louisiana State Medical Society for giving us the opportunity to testify on this important legislation. We will be happy to attempt to answer any questions the committee may have concerning our testimony.

LOUISIANA STATE MEDICAL SOCIETY—EXHIBIT A—SPECIAL ISSUE ON HMO'S

HMO's—What they're all about

The most frequently heard expression at medical meetings today is "HMO's". The ill-informed physician or one with impaired hearing might think he's hearing "HOMO's", another popular item of discussion these days. Please be assured that "HMO's" are not related to any sexual disorder. It is the politician's and planner's panacea for any and all of the nation's medical and health care problems whether they be real or imaginary.

What is an HMO?

The letters "HMO" stand for Health Maintenance Organization. An HMO is a public or private group providing a scope of medical benefits on a prepaid

capitation basis. Examples of existing organizations that would fit the accepted definition of an HMO include the various Kaiser plans, the HIP plan in New York and the Stanocola plan in Baton Rouge, Louisiana.

So what's new about HMO's?

While HMO's have been around a long time with varying degrees of success, politicians and planners have just discovered them and decided that they are the answer to all our problems and that they should be pushed, promoted and subsidized by the federal government as a major part of the various national health insurance programs now being considered by the Congress.

Why the sudden interest in HMO's?

Those promoting comprehensive, all-inclusive national health insurance programs now realize that the costs would be literally astronomical and that some way must be found to control costs. They contend that better health and medical care can be delivered at a lower cost through the utilization of HMO's.

Who are some of those promoting HMO's?

H.R. 1 (The Social Security Amendments of 1971) which has been approved by the House Ways and Means Committee strongly endorses the HMO concept. The Administration is sponsoring HMO legislation (S. 1182 and H.R. 5615), as are the insurance industry, Senator Edward Kennedy and others. All of those proposing HMO legislation call for it to receive heavy financial support from the federal government.

Who could form an HMO?

Almost anyone under the Administration's proposal. It could be a medical society, insurance company, medical school, Blue Cross, Blue Shield, hospital, the local office of Economic Opportunity or any public or private organization that meets certain government standards.

What are some of the requirements for forming an HMO?

According to the Administration Bills (S. 1182 and H.R. 5615) to qualify for federal assistance an HMO must:

(a) Provide (either directly or through arrangements with others) health services to individuals enrolled on a per capita prepayment basis;

(b) Provide (either directly or through arrangements with others) all those health services which a defined population might reasonably require in order to be maintained in good health, including as a minimum; emergency care, in-patient hospital and physician care, ambulatory physician care, and out-patient preventive medical services;

(c) Provide physicians' services directly through physicians who are either employees or partners of the HMO or under arrangements with one or more groups of physicians (organized on a group or individual practice basis) under which each group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of the group are paid on a fee-for-service or other basis;

(d) Demonstrate proof of financial responsibility and capability of providing comprehensive health care services, including institutional services—efficiently, effectively and economically;

(e) Have arrangements for assuring that the health services required by its members are received promptly and appropriately, meeting quality standards established in accordance with regulations of the Secretary of HEW;

(f) Have an open enrollment period at least every year under which individuals are accepted in the order in which they apply, up to the limits of its capacity and without restrictions except those authorized by HEW (at least half of the enrollees must be under age 65);

(g) Agree to keep all records and make all reports required by the Secretary of HEW; and

(h) Have assured that the State Comprehensive Health Planning Council and the local health planning agency (if any) have had an opportunity to comment on the application.

What about medicare and HMO's?

Under the envisioned HMO proposals, Medicare beneficiaries can enroll in HMO'S with payment made for them by the government at a level of 95% of the estimated and adjusted amount that would have been incurred by Medicare under conventional reimbursement methods.

What about the future HMO's?

Federal laws are usually broad and the HMO bills are no exception. Until specific regulations on HMO's are issued by HEW, we cannot accurately predict whether or not the HMO concept will actually meet the Administration's expectations or better serve the needs of our patients. Federal officials have stated that by 1980, 90% of the entire population of the nation should have available to them an HMO as an alternative to the currently available means of receiving health care, and that approximately 25% of the population should have elected to belong to an HMO.

How will new HMO's be financed?

S. 1182 and H.R. 5615 authorize the Secretary of HEW to make grants or contracts with HMO's to assist them in planning for the development of an HMO, and to pay all or part of the initial operating costs which are incurred as a result of its operation in a "medically underserved" area. Provision is also made for loan guarantees for the establishment of new private HMO's as well as grants and loan guarantees for HMO applicants who will provide new or expanded health services to a "medically underserved" area.

What is the LSMS position on HMO's?

The Louisiana State Medical Society strongly opposes the proposed concept of federal funding of capital costs for the establishment of HMO's for the reason that the HMO concept has not been proven to be a less expensive or a more efficient means of delivery of health care services. The LSMS believes that when administrative costs are added, HMO's may be a vastly more expensive system of providing health, care services with no guarantee that it will provide better quality.

Is the LSMS totally opposed to HMO's?

No. The LSMS supports the HMO concept as an experimental system for the delivery of health care services that should be carefully studied in limited areas to establish the validity or the non-validity of this concept. The LSMS, however, is opposed to federal subsidies and funding for HMO's.

Proponents' views

1. HMO's, by virtue of their contractual assumption of responsibility for a defined range of services at a negotiated per capita rate, could have wide latitude (subject to legislation and regulations) to make their own professional decisions, establish priorities for patient care and exercise self-discipline in assuring the adequacy and quality of services provided.

2. HMO's, as entities under contract to provide care for a defined population, could plan and justify their present and foreseeable needs for facilities, equipment, professional and ancillary manpower, and other capital and operating costs.

3. HMO's could assure the delivery of medical services more efficiently and effectively than fee-for-service providers, at a predetermined cost to government and to the consumer.

4. HMO's could have economic incentives to utilize modern business techniques and new types of health manpower, to provide coordinated care, to avoid duplicating services, and to utilize the least expensive care appropriate and adequate to a patient's needs.

5. Groups of physicians receiving capitation payments could, based upon peer decisions, remunerate their physician members on any basis, including fee-for-service.

6. HMO's could provide economic incentives to professionals to keep people well by emphasizing preventive services and ambulatory care. By taking responsibility for a defined population at a predetermined capitation rate, a disincentive could be created for unnecessary services, taking the place of external regulation and utilization surveillance.

7. Well-managed (administratively and professionally) HMO's could prosper. Enrollees of HMO's that do not survive can either choose another HMO or return to fee-for-service providers.

8. HMO's could help to assure continuity, accessibility and availability of patient care; these are sometimes inadequate to patients in certain geographic areas.

9. Recipients of public programs could be cared for as regular (mainstream) patients, both administratively and professionally. Prior authorization from external agencies for hospitalization might not be required.

10. The variety of possible patterns of innovation for HMO's is reflected in the interest on the part of such diverse organizations as private health insurance carriers, the "Blue" plans, hospitals, consumer groups, medical schools, medical societies, industry, business corporations and group practice plans. HMO's could represent another component of a private-public partnership committed to a pluralistic and competitive health care industry.

11. The advocacy of HMO's by the Administration reflects its desire to place the entire responsibility for peer review, costs of, and accessibility to, medical care in the hands of the medical profession which has the capability and capacity of utilizing this kind of mechanism in fulfilling its professional and economic responsibilities in the provision of adequate medical care to the public. HMO's could consist of different forms of practice arrangement as an acceptable alternative to the Kennedy and other proposals which present fewer opportunities for professional acceptance.

12. The emergence of the HMO could establish a mechanism geared to utilize competition and modern technology for the health care industry on behalf of the professional and public interest.

Opponents' views

1. The entry of profit-oriented organizations into the health care industry could produce a crop of HMO's out for a "quick buck". This could not only be destructive to the HMO concept but could also be disadvantageous and harmful to the patient.

2. Fiscal soundness has first priority; a fixed price contract forces economical operation in a highly competitive market. Widespread "cutting of corners" would be to the disadvantage of the patient. External mechanisms (government or peer) would be required to provide ongoing monitoring of services and compliance with the contract.

3. Since the quality of medical care can only be evaluated by professionals, an additional burden would be placed on the already over-extended physician supply due to the requirements which new regulations could impose upon them as participants in an HMO.

4. The HMO is exposed, just as are other health insurance mechanisms, to the risk of costs overrunning the contractually stipulated rate because of skewed and adverse enrollment selection, over-utilization from unforeseen catastrophic conditions or expenses, or from incorrect budget estimates. The opportunity to build a surplus for contingency may not be available.

5. There is reason to be concerned that the HMO will attract a disproportionate enrollment of poor risks. HMO's would be particularly attractive to persons who have a high need for care; this could include the homebound elderly.

6. A HMO's contractual rate commitment would cover in and out-of-hospital services. Hospitals are subject to conditions which can increase costs, only some of which are predictable; other costs, such as wages, which go into unit costs, are beyond the control of professionals. In such a situation, the fixed rate could force a reduction in payments to professionals.

7. Financial hardships are likely to be created for enrollees of relatively small and independent HMO's with limited access to highly specialized professionals and facilities. Use of services outside the HMO would be barred except for an "emergency", or if contracts specifically provided for such specialty services. This would also apply to enrollees requiring care while traveling.

8. The actuarial justification of an HMO's rate, including adjustment for services rendered outside the HMO, and ongoing evaluation, will require specially qualified governmental staff of formidable proportions. If such personnel are not available, government might have to resort to arbitrary guidelines which were not applicable to specific situations.

9. Physicians in a HMO would function as "providers of services" in their relationship to government, and would be required to comply with regulations regarding quality, administration and finance. This relationship differs from present government control in that the current relationship is with the intermediary—and the physician has an indirect involvement.

10. Prepaid group practice programs (and this could apply equally to other types of practices qualifying as HMO's) have frequently resulted in impersonal care, lengthy waits for appointments and an impression of deterioration in the quality of medical care provided.

11. The lack of mobility of the "captive" patient, i.e., freedom to select a physician outside the HMO, at a time when care is needed but not available, would be inimical to the provision of good quality medical care.

12. There is no guarantee that the formation of HMO's would result in greater accessibility and availability of medical care—two of the major stated justifications for the creation of HMO's.

Conclusion

While more can be said both "pro" and "con" about HMO's, the Louisiana State Medical Society must regard this concept as only one experimental plan to encourage innovation in the organization and delivery of health care services. The Louisiana State Medical Society strongly favors innovations that provide high quality medical care at reasonable costs to all segments of the population. However, these must be within the framework of the competitive marketplace with no system receiving federal subsidies that would discriminate against the private, fee-for-service concept for the delivery of health care.

EXHIBIT B

[From the Federal Register, vol. 35, No. 253, Dec. 31, 1970]

[Regs. No. 5, further amended]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED (1965—)

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

Determining Prevailing Charges

Section 1839(b) (2) of the Social Security Act, as amended (42 U.S.C. 1395 et seq.), requires the Secretary of Health, Education, and Welfare to promulgate before the end of each year, the dollar amount which shall be applicable for supplementary medical insurance premiums for months occurring in the 12-month period commencing July 1 in each succeeding year. In determining the amount of the monthly premium, it is necessary that the method by which carriers will determine the prevailing charge limit for each medical service or procedure be established.

The Secretary of Health, Education, and Welfare has determined that carriers may recognize charges which fall within the 75th percentile of the customary charges made for similar services in the same locality during the calendar year preceding the start of the fiscal year in which the determination is made.

Because of the immediate need for determination and publication of the premium rate for the period beginning July 1971, and ending June 1972, and since such premium rate determination must take into consideration this amendment of the regulations, the Secretary finds that notice of rule making and public procedure with respect to the amendment to regulations set out below are impracticable and are therefore dispensed with, and also that such amendment shall be effective upon filing with the Office of the Federal Register.

Consideration will be given, however, to any data, views or arguments pertaining to said amendment for the purpose of suggesting modifications or additions thereto, which are submitted in triplicate not later than February 1, 1971, to the Commissioner of Social Security, Department of Health, Education, and Welfare Building, Fourth and Independence Avenue SW., Washington, DC 20201.

Regulations No. 5 of the Social Security Administration, as amended (20 CFR 405.1 et seq.), are further amended as follows:

Paragraph (a) of § 405.504 is revised to read as follows:

§ 405.504 Determining prevailing charges.

(a) *Range of charges.* The term "prevailing charges" refers to those charges which fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. The top of this range establishes, except as provided in § 405.506, an overall limitation on the charges which a carrier will accept as reasonable for a given medical procedure or service. Prevailing charges are derived from the overall pattern existing within a locality. For example, in a given locality the carrier may find that the charges most frequently and widely used by physicians for a particular medical procedure range from \$150 to \$175. If in another locality the carrier finds that the prevailing charges are different for the same procedure, then a different range of charges would be applied in making reasonable charge determinations for that locality. With respect to claims received by carriers on and after January 1, 1971, no charge may be determined to be reasonable if it exceeds the higher of (1) the prevailing charge limit that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the calendar year preceding the start of the fiscal year in which the determination is made, or (2) the prevailing charge limit in effect on December 31, 1970, provided such prevailing charge limit had been found acceptable by the Secretary.

(Secs. 1102, 1842 (b), and 1871, 49 Stat. 647, as amended, 79 Stat. 310, 79 Stat. 331; 42 U.S.C. 1302, 1395, et seq.)

Dated: December 18, 1970.

ROBERT M. BALL,
Commissioner of Social Security.

Approved: December 28, 1970.

ELLIOT L. RICHARDSON,
Secretary of Health, Education, and Welfare.

[F.R. Doc. 70-17651; Filed, Dec. 30, 1970; 8:51 a.m.]

EXHIBIT C—AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES— RESOLUTION 36

Introduced by: Louisiana Delegation.

Subject: So-called "Peer Review" for Economic Purposes.

Referred to: Reference Committee A (John T. Pewters, M.D., Chairman).

Whereas, Under the guise of "Peer Review," government and third parties are demanding unlimited access to entire medical charts including the most confidential aspects of these records for the states purpose of making judgment of physician performance per se as to the medical necessity of actions of physicians in the practice of medicine to be termed a medical audit. Such action is in direct violation of Section 1801 of the Medicare Act¹; and

Whereas, This is "Peer Review" by non-peers; and

Whereas, The Director of the Bureau of the Health Insurance of the Social Security has ruled that no payments will be made to providers of services that are found not to be medically necessary in the judgment of Blue Cross and other third party carriers, and that the threat of withholding already earned Medicare and Medicaid funds due to providers for prior rendered services, who fail to grant complete access to entire medical records is also in violation of Section 1801; and

Whereas, The justification for this new policy as stated by Blue Cross, other fiscal intermediaries for government health programs and other third parties is to prevent payment for fraud. It should be noted by all that American medicine has long established adequate mechanisms for self control, this being accomplished by hospital in-service control committees such as utilization, tissue, and other control units and out-patient controls at the local and state levels with means for complete arbitration and appeal; and

Whereas, These stated mechanisms of self control and true judgment by peers make unnecessary such efforts by government and third party insurance carriers

¹ Section 1801 of P.L. 89-97: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

who have only an economic interest in payment for cost of services and that Peer Review by parties outside of organized medicine would be intolerable to private practicing physicians; therefore be it

Resolved, That the House of Delegates of the American Medical Association does instruct its officers to pursue by all means possible, including, if necessary, court action, to bring about that no third party insurance carrier, or any other body, however structured, outside of the already established mechanisms within the self-control concepts of organized medicine shall act as a Peer Review body to make judgments of physician performance per se; and be it further

Resolved, That third parties who have only an economic interest in payment of medical costs shall not violate the patient-physician relationship and have access to the confidential aspect of private citizens' medical records for any purposes; and be it further

Resolved, That any means necessary to accomplish these objectives including withdrawal of all cooperation with any present or future government health programs by the American Medical Association, shall be utilized.

Resolution 36 calls for a clear distinction between the peer review responsibilities of the medical profession and the claims administration functions of various private health insurance carriers and government agencies. The resolution also urges these carriers and agencies to rely on established peer review mechanisms for the adjudication and resolution of issues which require professional medical judgment.

Your Reference Committee is fully aware that this issue has been addressed by the House of Delegates on a number of prior occasions and that strong efforts are being made at all levels of organized medicine to resolve the difficulties to which this resolution refers. Your Committee believes that the following Substitute Resolution will serve to reemphasize the need for continuing and strengthening that effort:

Resolved, That the American Medical Association urge all health insurance carriers and government health financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning the quality, cost or utilization of medical services which require professional judgment; and be it further

Resolved, That the American Medical Association reaffirm that it is the responsibility of state medical associations, county medical societies, and hospital medical staffs to create active and effective systems of peer review which are responsive to the needs of their respective communities; and be it further

Resolved, That peer review programs shall have as their goal both improved quality of medical care and more efficient delivery of medical services.

Recommendation

Mr. Speaker, your Reference Committee recommends the *adoption of the Substitute Resolution in lieu of Resolution 36*.

The Substitute Resolution was approved by the House of Delegates.

The CHAIRMAN. Now, the hour is late for this morning's session. We are now at 12:40, so we will come back in here at 2:30 to hear the remaining witnesses.

Thank you very much for your presentation today.

(Whereupon, at 12:40 p.m., the hearing was adjourned, to reconvene at 2:30 p.m. this date.)

AFTERNOON SESSION

The CHAIRMAN. We will now hear from the Council of Medical Staffs, Dr. J. Garcia Oller, accompanied by Dr. Edward S. Hyman. Doctor, we obtained a screen because you wanted to use some slides.

STATEMENT OF JOSE GARCIA OLLER, M.D., PRESIDENT, AMERICAN COUNCIL OF MEDICAL STAFFS, ACCOMPANIED BY EDWARD S. HYMAN, M.D., SECRETARY, ACMS

Dr. GARCIA OLLER. Thank you, Mr. Chairman.

I am Dr. Garcia Oller, Council of Medical Staffs. I have with me, as you mentioned, Dr. Edward S. Hyman who is secretary of the Coun-

cil of Medical Staffs, and to my right I have Dr. Wesley Segre, who is vice president of the Black Physicians' Association, the Negro medical association in Louisiana; and to my extreme right the vice president, Dr. Robert Meade who is a plastic surgeon; and to my left Dr. Kenneth Ritter, also vice president and a practicing psychiatrist.

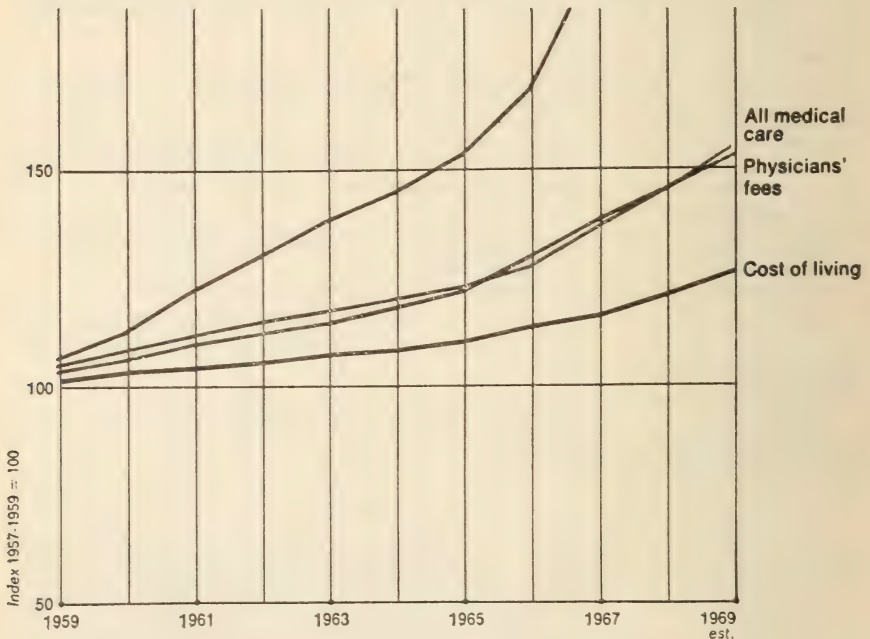
Mr. Chairman, the Council of Medical Staffs is an organization which brings you greetings from Louisiana, but at the present time we are having voting membership in 15 States.

The concept of the council is that the private practicing physician, the one who delivers the medical care at the bedside, should become involved in the national dialog as to the future of health care in this country, and we appreciate the opportunity for these comments on H.R. 1.

The council feels that private practice provides the highest quality of medical care and at the lowest cost.

Our function is to research the facts on medical care and bring them to the attention of your committee.

If I may have the first slide, we feel that H.R. 1, and most of the current national legislation, is based with the understandable preoccupation with the rising medical costs and the high cost of health care in general, and I feel that it is important that we should look at these basic facts now before you which, in our opinion, constitute some basic deceptions to which the American public has been subjected.

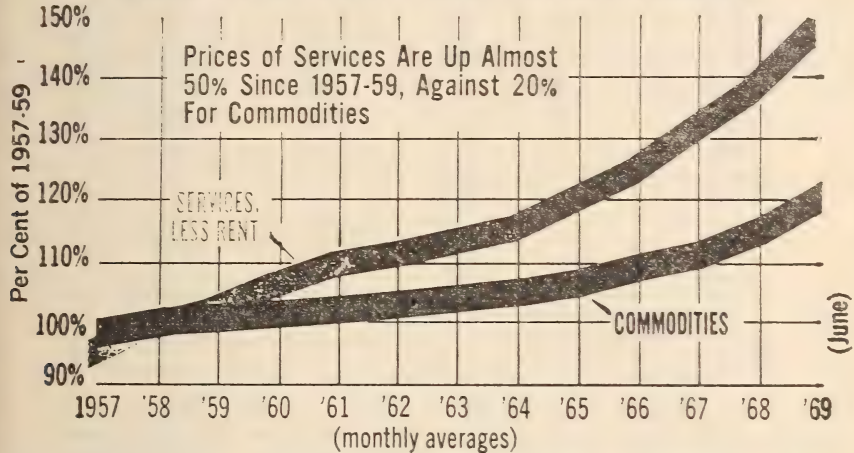


No. 1: Deception No. 1, that the cost of medical care is rising higher than the Consumer Price Index. This is a graph taken from Fortune magazine showing a 10-year span.

The baseline is 100 and 10 years later all medical care and physicians' fees have risen 50 percent. That is a 5-percent rise average over a 10-year period; and the statement is then made that the cost of living, the CPI, has risen about 30 percent and this disparity is often quoted as an inordinate rise.

I would like to mention why this is a fallacy.

WHERE LIVING COSTS HAVE SOARED HIGHEST



Source: Bureau of Labor Statistics, consumer price index

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This slide shows an identical set of curves—the same 10-year span, two curves, one goes up 50 percent, the other goes up 25 percent. The upper curve is a curve for services in this country and the lower curve is for commodities. Both of these are components of the Consumer Price Index, CPI.

Now, I submit, Mr. Chairman, that medical care is a service and if we compare medical care as a service with all services in this country—television, plumbers, et cetera—the same 50-percent rise is seen identical to that of medicine in the previous slide—50 percent for medical care, 50 percent for all services.

Table 10-5. Comparison of Annual Increases in Physician Fees and in Wages

<i>Calendar Year^a</i>	<i>Physician Fees^b</i>	<i>Average Wages in Covered Employment</i>	<i>Differential Increase of Physician Fees</i>
1956	3.1%	5.7%	-2.6%
1957	4.4	5.5	-1.1
1958	3.4	3.3	.1
1959	3.9	3.3	.6
1960	1.8	4.3	-2.5
1961	2.6	3.1	-.5
1962	3.1	4.2	-.9
1963	2.2	2.4	-.2
1964	2.3	3.1	-.8
1965	3.3	1.6	1.7
Average, 1956-65	3.0	3.6	-.6
1966	5.9	4.4	1.5
1967	7.3	6.3	1.0
1968	5.5	7.0	-1.5
Average, 1956-68	3.7	4.2	.5

^a Increase from June of previous year to June of year listed for first column and from first quarter of previous year to first quarter of year listed for last column.

^b As measured by Consumer Price Index of physician fees.

I believe it is important that we realize that medical care as a service has risen identically as all services in this country; further, that medical care constitutes only 6.7 percent of the family budget while food, housing, household transportation, et cetera, have a higher segment of the family budget and yet as from this next slide you will see that these other elements that form a higher portion of the family budget have risen much higher than medicine.

Here are the 2 years, the first 2 years, of medicare. Medical care in the first 2 years of medicare went up 12.9 percent, meals in restaurants the same or higher, men's clothing, women's clothing, shoes—medical care has risen the same or less than these elements of the family budget that are a larger component.

Mr. Chairman, the second deception, the inordinate rise of physicians' fees—this is taken from Dr. Myers' book on medicare and shows a 12-year plan of physicians' fees which averaged 3.7 percent over the 12-year span. Average wages in covered employment under social security in the same span, 4.2 percent; so, Mr. Chairman, I would submit that physicians' fees have risen less than covered employment over the same period of time.

We have seen that there is a statement that there has been a 39 percent rise over 5 years on physicians' house calls. I would submit, Mr. Chairman, that \$13.80 compares favorably with the bill rendered for the trip to and from the house by the television man, the repair man, and the plumber; and I think the American public has a bargain.

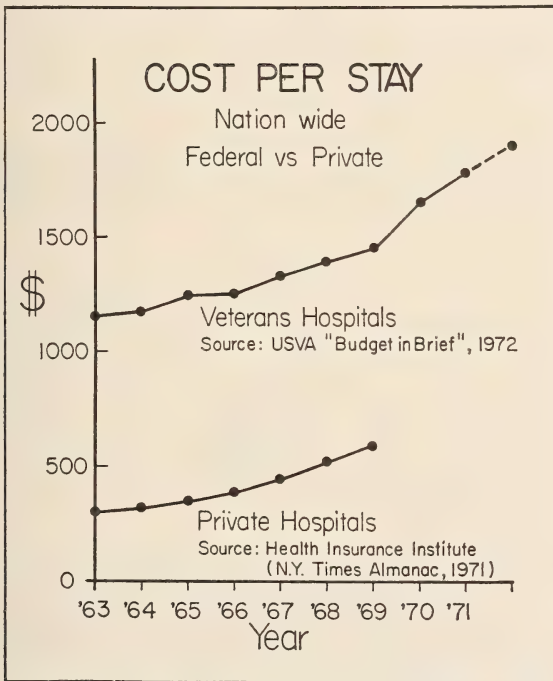
Here we have 1971 rises on plumbers, plasterers, et cetera, from 12 to 15 percent in 1 year and, Mr. Chairman, if the plumbers work the

62 hours that the average physician works in this country, I believe it is fair to state that the plumber, with a double pay for overtime, would make a more handsome fee than the average physician in this country.

Here are the recent labor contracts, 10 percent per year for the auto industry; telephone industry the same 3 years, 30 percent; the steel industry the same, and railroads.

The third deception, Mr. Chairman, is a statement that if we could impose a system of hospitals under the Federal aegis that it should be possible to reduce the cost of hospitalization below that of the current private so-called nonsystem.

We have here a study which we made of our private hospitals in the New Orleans area, Mr. Chairman, and you will see that the bill at the end of the average patient's stay varies from \$392 to \$648. This is the private hospital bill of the average patient which on a national average is an 8-day stay.



If we compare them with the State system charity hospital or with the federal system, let's say, Veterans' Administration and Public Health Service, we will see that the average bill to the U.S. Government is \$1,093 for veterans, which is considerably above our most expensive private hospital, and Public Health Service, \$922 which is higher than the private hospital system.

Here, from the Federal budget, it was inquired when we made some of these presentations maybe there are some hidden costs. If we make a study from the Federal budget we find that the actual cost per stay in the veterans hospital is around \$1,750, which is nearly—which is

much higher, if you will, than the \$600 average per private hospitals in this country.

So it would appear when it is felt that a federal system has had an opportunity to be ripened, controlled and developed under all of the checks and balances of the federal system, there is a marked disproportion and higher cost obviously due to the increased per unit expense of adding the regimentation and the bureaucracy that must be paid for.

	Per diem	Days stay	Cost per stay
Ochsner.....	\$67.0×	9.61	\$648
Touro.....	78.1×	8.20	640
Hotel Dieu.....	71.2×	7.74	552
Flint.....	49.6×	10.4	514
Baptist.....	60.9×	7.9	480
Mercy.....	68.0×	6.86	467
Mayo.....	64.2×	6.10	392
Charity.....	43.3×	14.1	637
USVAH.....	49.6×	22.0	1,093
USPHS.....	52.0×	17.7	922

Source: Hospitals, August 1969.

Formula Used: (1) per diem=Expense/patient days. (2) length of stay: Patient days per patient=census × 365/no. admissions.

This slide shows, Mr. Chairman, that in a year's time each of the private hospitals rose an amount less than the charity hospitals and the Veterans' Administration hospitals, so the Federal hospitals are not able to hold down the costs.

LENGTH OF STAY

[In days]

	Year to September—		Differ- ence		Year to September—		Differ- ence
	1968	1969			1968	1969	
Ochsner.....	9.61	9.57	-0.04	Mercy.....	6.86	7.04	+ .18
Touro.....	8.20	8.77	+ .57	Sara Mayo.....	6.10	6.08	- .02
Hotel Dieu.....	7.74	8.06	+ .32	Charity.....	14.1	14.2	+ .10
Flint.....	10.4	10.7	+ .30	USVAH.....	22.0	23.5	+1.50
Baptist.....	7.90	7.88	- .02	USPHS.....	17.7	19.0	+1.20

Source: Hospitals (JAHA) August 1969 and 1970.

Then the matter of utilization, and we have here a slide where we find that if the Veterans' Administration hospital and the Public Health Service hospital and the charity hospital had the occupancy of 8 days, which is the average hospital stay in this country, these three hospitals together could be put in one place and the other two closed.

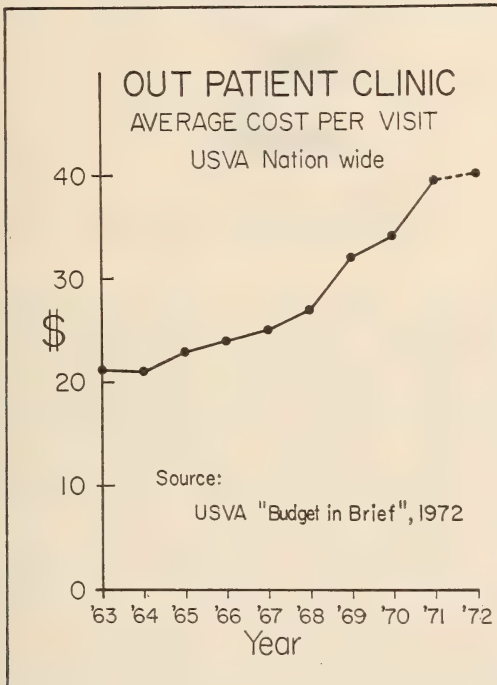
COST PER YEAR

	Year to September—				Year to September—		
	1968	1969	Difference		1968	1969	Difference
Ochsner.....	\$648	\$737	\$89	Mercy.....	\$467	\$548	\$81
Touro.....	640	823	123	Sara Mayo.....	392	473	81
Hotel Dieu.....	552	670	118	Charity.....	637	742	105
Flint.....	514	533	19	USVAH.....	1,093	1,251	158
Baptist.....	480	530	50	USPHS.....	922	1,072	150

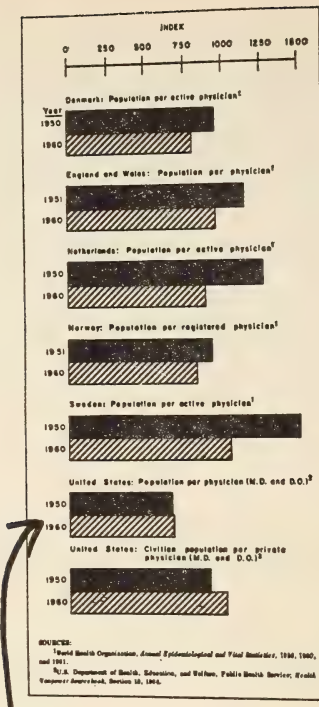
Source: Hospitals (JAHA) August 1969 and 1970.

The next deception, Mr. Chairman, is that the creation of a system of outpatient clinics under a Federal system could perhaps be less expensive and more efficient than the current private physician offices. From the budget of the Veterans' Administration to the average cost per visit is \$39.50 which, I submit, a \$39.50 office visit is a bit higher than you will find around private offices around the country.

One of the reasons we submit why the Federal system finds the costs to be prohibitive is that we have found that there is very little incentive in the Federal system, Mr. Chairman, to have these patients discharged. The system—the budgetary system—is such that the patient days determine the budget allocated to the Veterans and Public Health systems and there is very little incentive for these patients to be discharged, resulting in what appears to be a lower per diem but unfortunately a very long stay, so that the cost of medical care per patient becomes higher.



The next statement, the deception we hear is that we have a doctor shortage. Here, again, from an official governmental publication the relation of population in the upper bar population, to the number of physicians—the first black bar is the number of physicians, the scale above the population. The shorter the bar the more doctors and you will notice that Denmark, England, The Netherlands, Norway, Sweden, all of them have longer bars, fewer patients per population than the United States.



The United States leads, Mr. Chairman, the free world in the number of physicians per population, except for Austria and Israel.

It is true from this map showing the distribution of counties in this country that we have not been able to supply physicians for every county. In this map the black areas are the standard metropolitan areas. The gray areas are counties without a doctor. There are 132 of these at the present time. Thirty-two of these counties are in close proximity to the standard, large metropolitan areas. Many of these counties, as you will notice, are close to Death Valley, to the deserts in Texas, to the national parks and lakes, and we have not been able to achieve a doctor for every county, but I think it is a miracle of modern medicine that we have expanded the great majority of counties and certainly in the great States of Louisiana and Arkansas and I should consider there are very few counties without a doctor.

The next deception, Mr. Chairman, is what we call the cruel hoax imposed upon the people, that we have second-rate medical care because of a high infant mortality.

Mr. Chairman, may we submit this information: From the demographic yearbook in 1963 in this country 97.4 percent of births occurred in hospitals. Now, from the next slide you will see that in The Netherlands, which has the second lowest infant mortality, only 30 percent of babies are born in hospitals.

Mr. Chairman, if a baby is born in a hospital in this country, and 97 percent of them are so born, it is the responsibility of the doctor by law to report that delivery, birth, or death, within 24

hours. So we have a very accurate system of reporting. I submit that in the socialized countries where we have most of the births occurring at home, under midwives, where the responsibility for the recording of the death may be any relative, and the time may be from weeks to years, I would submit that under the system of the socialized countries we have a defective reporting mechanism because in this country 97 percent are born in hospitals, and if they die they are reported; while in the others they may never be reported.

It is important, we feel, that we discuss not the infant mortality, which is usually due to prematurity which little can be done about, but we compare the death rate, not the infant mortality, but the death rate for treatable diseases and we have submitted this slide to you showing the death rate in Sweden versus the United States for treatable disease.

DEATH RATE, Sweden vs. U.S.A.

(Deaths per year per 100,000 population)

All Causes_____	+	8.5%*
Pulmonary Tuberculosis_____	+	25.
Suicide_____	+	95.
Benign Peptic Ulcer_____	+	78.
Pneumonia_____	+	84.
Influenza_____	+	200.
Benign		
Prostatic Hypertrophy_____	+	116.
Neoplasms_____	+	21.5
Stroke_____	+	13.7
Diabetes_____	+	5.0
Senility_____	-	22.
Hypertension		
with Heart Disease_____	-	30.

*Sweden exceeds U.S.A. by 8.5%

ref: U.N. Demographic Yearbook, 1968

All causes, 8.5 percent more deaths in Sweden; tuberculosis, 25 percent more mortality. In this country, Mr. Chairman, as you know, we are closing many of the TB sanatoria because of the modern drugs.

Suicide, 95 percent higher in Sweden. Benign peptic ulcer, which is certainly a treatable disease, 78 more deaths from peptic ulcer. It is not just a matter of having the disease but not having the availability of treatment in time to prevent a mortality from a fatal hemorrhage.

Pneumonia, 84 percent. Influenza, over 186 percent. Benign prostatic hypertrophy, in the elderly a common disease, 116 percent more deaths in the elderly group due to a treatable disorder.

Tumors, 21 percent more deaths. Stroke, diabetes and, finally, where we trail is that we have more senior citizens dying from old age in this country, 22 percent more than we have in Sweden.

Now, the second part of the presentation, Mr. Chairman, refers to the problem that we practicing physicians have in relation to being able to influence and modify the tremendous bureaucracy that has been imposed upon us.

Now, we come here today to you, Mr. Chairman, and this committee, to appeal to you to guide us in which way we can find responsibility and accountability in government, as you yourself have stated. Here in Nation's Business on your welfare costs interview, you made the statement which we will enlarge:

"We have found that HEW estimates of costs of important programs have oftentimes been as low as 10 percent of what a program actually costs after a year or 2." And, as you know, very often the rising costs of medicare and medicaid are ascribed to physicians' inadequacy.

Here is another statement from your same interview: "The Department of HEW is spreading fraudulent propaganda about their welfare programs," and, there again, time and again it is the doctors who are at fault, Mr. Chairman.

And, finally, this is the problem, "We are still trying to find ways to improve under the work incentive program the difficulties that those people in HEW who seem to stay there no matter who is President have plans for the contrary. The logic of some of that scheming is almost beyond belief."

Mr. Chairman, these are, I know, strong words, but from a man who is an expert, it causes us to consider our plight. This is what our dealings have been, Mr. Chairman, with one simple problem with HEW, and we will make a specific recommendation for your committee to consider repeal of this section 1814, the conditions of and limitations and payment of services which require certification by a doctor that the patient is sick and has to be in the hospital.

I am sure the intent of Congress was well meaning, that not later than the 20th day of hospitalization the physician should certify the reason for continued hospitalization.

Mr. Chairman, this appear reasonable on its face since the average hospitalization is 8 days, but what happens when we enter the bureaucracy where the regulations take over, Mr. Chairman, through what we call the tyranny of the Federal Register? We call it this because if within 30 days the physicians in this country have not read the Federal Register, the regulations that bind them becomes law. It has the effect of law.

Now, what is our experience with this well-meaning intent of Congress, Mr. Chairman? This is a HEW News of October 1969, in which they stated that the physicians were keeping the patients in the hospital too long in medicare and by tightening the certification regulations social security had been able to force these doctors to discharge their patients.

Now, Mr. Chairman, this is a statement made: "To illustrate the potential cost savings to the program medicare costs will be reduced by approximately \$400 million." They made an illustration that the

costs will be reduced by \$400 million if each hospital stay by a medicare beneficiary is shortened by 1 day.

So social security imposed a new regulation or announced it with this news, that the new regulation would put these discharge dates back by pushing the certification back; by requiring certification earlier, they were going to force the doctors to discharge their patients earlier. They not only stated that but they also said they had data, Mr. Chairman, to prove that the discharges had, indeed, responded to the regulations and there is no apparent medical reason for these discharges and, therefore, we will get rid of these unnecessarily prolonged hospital stays.

Now, this appeared in all of the news media in this country, that patients were having unnecessarily prolonged hospital stays and that HEW had found a way to discharge them and forced these terrible doctors into line.

Now, Mr. Chairman, we are men of the truth, we feel, in this country and we requested the data. We felt that if this was true, we would like to find out and put the house of medicine in order; so we asked for the data, Mr. Chairman, through our congressional representatives and these are the data we eventually received: that each week there were some peaks of discharges.

Now, Mr. Chairman, we calculated these peaks effected by the regulations and if the regulation worked there would be an estimated \$4 million saved. From the data of HEW, Mr. Chairman, if the regulation had succeeded, \$4 million might be saved in the program. The illustration given to the American public was \$400 million, and I will say, Mr. Chairman, if you have experienced a 10 percent out of 100 percent estimate, we have experienced from \$4 to \$400 million in the press, and "This is what the doctors are doing to cheat the public and we are going to straighten them out," but they can't add up to 400 in HEW.

Now, Mr. Chairman, these peaks were claimed by the Social Security Administration. Each peak there is a peak of discharges, a very small peak and is actually a mathematical rate; it is not actually an increase of discharge. If we look at these peaks and we compare the peaks that existed before medicare, we find out here is the solid line which is before medicare for peaks, and after medicare for peaks, and Mr. Chairman, if the peaks of discharges had a natural weekly cycle before medicare, how can social security say they invented these peaks by creating a regulation "to force these no good doctors to discharge their patients"?

We did not invent the calendar or the phases of the moon. Illness does have statistical cycles of weekly intervals. They were present before medicare and we felt then that from our studies that social security should know that this is not in relation to the regulation, and we requested that they repeal this regulation, Mr. Chairman.

We wrote a book which we presented to them. We received monthly letters saying they would study it and give it consideration. This is the first experience of the private doctor.

One year later we obtained a study from PAS, which is a participating study of thousands of hospitals in this country and we found that after the regulation was imposed, because social security paid no

attention to our presentations; they said they would study the matter; 1 year later the peaks were still there, totally unaffected by the regulation because they were there before medicare and they are still there.

The question we ask, Mr. Chairman, is that we have come back to social security; we have had meetings with our congressional representatives and social security; they have this information; they know it has been a fraudulent presentation, because there is no relation between the peaks of discharges and the regulation; but they have continued to send us letters—the last one last week—that they are studying the problem and they are looking at the latest computer figures.

Now, here is a letter from Dr. Robert Myers in which he states:

On the day after the HEW news release was made saying that the doctors were keeping their patients too long. I brought out that the savings of this change will probably be about \$5 million a year. I think that the method of presentation is most misleading and tends to create a credibility gap for the present administration that could have been avoided.

In other words, his computations were \$5 million, not \$400 million, and here is what is new in HEW; they made a statement a direct statement, that they could cut costs \$400 million; and, again, Dr. Myers has written to the head of social security, once again, "I must state that it is very dismaying that a credibility gap has been created."

This was long before we presented our studies, Mr. Chairman.

Now, this is our correspondence; this is what happens to the physician. We get a statement saying that is the way it is; here is another letter through our congressional representation when we tried to oppose the regulation. It was carried out anyway; and you may not believe this, Mr. Chairman—it is hard for us to believe—that all of this presentation, the way social security responded was, "This past year," that is, 2 years after the previous regulation they say they have so much success with it, "experience with medicare has shown that requiring certification by physicians reduces hospital stays."

They put out a second news release and the regulation that was a failure; now they are going to extend it to the poor people.

This is the way that social security is working. Since it worked so well with medicare, and we know it did not, so, again, our response, Mr. Chairman, was to ask for data through our congressional representatives and there was no new data. The statement was, "The data used to justify the proposed regulations on title XIX," that is, medicaid, "are the same as that developed by the Social Security Administration in 1969 and which I forwarded to you in December 1969." They had no new data, Mr. Chairman. They said they did. They are imposing this upon the doctors and the poor people.

The same comments come out in the newspaper that doctors need to be policed because they won't even take care of the poor people.

Now, Mr. Chairman, this is 2 weeks ago, January 26, by Mr. Robert Ball where he states, "We regret we were unable to meet our target date since we did not obtain all the necessary data until recently."

Mr. Chairman, in 1969 they said they had the data and this is 1972; and what can the private doctor do?

Mr. Thomas Tierney asked us, Mr. Chairman, if I may submit this, why were we worried about certification? It is merely just a piece of

paper. Does this cost much of the doctors' time? What is so onerous about it? Our comment, Mr. Chairman, is that the law will not allow payment under section 1814 unless the certification is filled out. Therefore, our hospital administrators make that certification paper the No. 1 item and soon the patient becomes incidental and the certification paper becomes the most important item in the hospital. We feel, then, that this example of how the private physicians in this country had tried to obtain relief and accountability from our Government and what happens is we keep saying, "Let's find out what the computer says," and in the meantime our entire hospital system is having an increasing bureaucracy where the patient becomes less and less important.

Mr. Tierney says, "that the period of accommodation is coming to an end with the medical profession." This is a quotation from Mr. Tierney. As HEW's keyman, Tierney has been deeply involved in the deliberations to strengthen peer review.

Here, Mr. Chairman, is the same Social Security Administration who still has not been able to come up with the data 3 years later for imposing regulations and he is again calling the medical profession to task.

Here is a prohibition against Federal interference and control that Mr. Tierney has threatened the profession and it is the law in this country that he should not do this, Mr. Chairman.

Finally, on the matter of regulations, I received this in my office last week. This is December 21 date, from social and rehabilitation services. These are instructions to State agencies administering approved medical assistance plans and this is establishing a preauthorization of selected types of medical care and services. That means that the poor people under medicaid will not have to have an independent committee decide whether they should be admitted to the hospital or not or treated, a screen for the poor, second-rate medical care.

Now, this is not authorized in the law, as we understand it, but the laws as they are written given such broad option to regulations, Mr. Chairman, that this is where the problem is. These gentlemen in social rehabilitation services are actually writing the law that the doctor will not make the judgment as to who comes into the hospital. It will be the Government committee, Mr. Chairman. This is a very sad day in history for us doctors if it is indeed going to come about that professional judgment is going to be by-passed and have a political committee.

This, on the matter, Mr. Chairman, of peer review: There is a section in H.R. 1 where, in section 222(a), in which there is a retrospective evaluation of medical services and there is under section 1122, the peer mechanism has been tied into compulsory area planning.

Mr. Chairman, all of us here today have had considerable experience in area planning in the health planning council. This is the computerized profile of physicians and from this you are going to determine whether the doctors are practicing proper medicine. This is going to be done by the computer kicking out above the norms and this is the kind of dollars you are going to save, Mr. Chairman. You had this on your medicare hearings last year; this is the San Joaquin Foundation for medical care. This is how they save money and you had some of this.

This is a letter written by the doctor chairman of the review committee. This is the peer review committee after they have been the computer profile: "Dear Doctor: Your patient at Convalescent Hospital received toenail trimming on January 31. If you authorized such treatment, please initial and return and if not would you please so state and return."

The doctor has written: "Yes; since that time she has become bed-ridden and treatment ordered discontinued. However, because of lateral inflammation of the ligament she will receive one more treatment."

The cost of this letter and the cost of the peer review physician and the bureaucracy involved here, Mr. Chairman, must far outweigh the toenail trimming costs.

The bureaucracy expense, 11 percent for physicians' fees, in medical in California, and 40 percent for operating overhead.

Whenever the unit costs are increased from the doctor in his office taking care of the sick, with one nurse, perhaps just one secretary, when the unit cost of that office, which may even be a two-room office, becomes a Federal unit cost, where we then have to have Federal inspectors and Federal peer reviews, and we have to have social workers in our offices and we have to follow all these regulations, the cost is going to increase.

Finally, Mr. Chairman, the concept of peer review, as you know, in medicare we are not allowed to give B-12 to the sick because it is unnecessary except under very few conditions. Here is a slide that shows that there are a whole set of new diseases which can be controlled with vitamins of the B complex, and doses hundreds to thousands of times of the normal dose.

Mr. Chairman, if you happen to have an infant with this type of aciduria, instead of needing one-millionth of a gram of vitamin B-12, you need one thousandth. The doctors who practice medicine have known for years that B-12 is a tremendously useful drug in the care of the sick, especially in diseases of the nervous system metabolism. Now, we have the proof but the practicing physician has to make his decision not by the computer and what is written in the book but by his experience, and I think if we come to computerized medicine with decision being made by books that were obsolete 10 years ago, I think progress has been stymied.

I feel that the federalized hospital is suffering from this disease.

Mr. Chairman, this is a photograph of one of our local hospitals in New Orleans and these are the seven people around the chart, and what happens to the 20 to 30 patients in that ward, Mr. Chairman? This is the plight of the private doctor: That as the Federal Government demands more and more documentation to prove the need for medical care, then the entire hospital system becomes geared to the paperwork and we have all this fantastic parasitism and proliferation of unnecessary people—and what happens to the patient? I think this is something that should be considered.

As we move into the Federal regimentation of medicine and HMO's—here is from Canada, Mr. Chairman, the Minister of Health in Canada, and this is what he just did in the District of Columbia:

"Spearheaded legislation under which doctors would be limited to three tests," all that the practicing doctor can give is three examinations—electrocardiogram, urinalysis and hemoglobin—and I think if

this should come to pass in this country, that there should be a prime minister of health with that power; I think that our patients will go back to the middle ages as far as medical care is concerned.

Mr. Chairman, our specific recommendations are, if you will, we appeal to you that your committee consider making a recommendation that section 1814 of the medicare law on certification be repealed because it has proven to be unnecessary, expensive and has become the vehicle of fraud.

I would like you to seriously consider our documentation which we will leave with you on our studies on this matter.

Second, we object to the establishment of compulsory areawide planning tied to peer review. It has been our experience, Mr. Chairman, as far as areawide planning is concerned, that ordinarily the Federal money is considered to be free money and it has been our experience that whenever a Federal project is brought to area planning it is seldom vetoed.

On the other hand, the private projects are usually subjected to very close scrutiny by the private individuals because of the risk of capital investment.

We feel that areawide planning has cost more in this country so far than the savings of reduplicating equipment for the last century. We are told that area planning, Mr. Chairman, is going to save money and this bill—H.R. 1—section 1122, makes areawide planning compulsory.

Mr. Chairman, the cost of areawide planning in this country would be sufficient to give everyone a cobalt unit and kidney facility and so on, that might be needed instead of spending all of this money on learning how to prevent it.

The CHAIRMAN. Doctor, you presented some very interesting information here. We have been trying to move under a 10-minute rule and we heard you for much longer than that, and I would appreciate it if you would summarize it. We will certainly read all your material.

Dr. GARCIA OLLER. Mr. Chairman, we certainly will close now and I want to thank you very greatly for this opportunity.

The CHAIRMAN. Thank you.

I am going to ask that our staff take this information, particularly that which is at variance with the publicized statements, and prepare us a memorandum, and I would hope that the agencies that initiated these statements could be offered an opportunity to comment as well.

Thank you very much.

Do you have any questions?

Senator JORDAN. Thank you.

The CHAIRMAN. Thank you so much, gentlemen.

Dr. GARCIA OLLER. Thank you.

(The statement and an attachment of Dr. Garcia Oller follow:)

STATEMENT OF THE COUNCIL OF MEDICAL STAFFS (AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.) PRESENTED BY DR. JOSE L. GARCIA OLLER

SUMMARY

While the CMS subscribes to the concept of adequate medical care for all, some of the HR 1 amendments immobilize medical practice at an unacceptable level, while others are based on suppositions yet to be proven.

The following fallacies concerning medical care are cited:

DECEPTION NO. 1.—“The Cost of Medical Care is Rising Higher Than the Consumer Price Index.”

DECEPTION NO. 2.—“The Inordinate Rise of Physicians’ Fees.”

DECEPTION NO. 3.—“The Imposition of a ‘System’ of Hospitals Under the Federal Aegis could Reduce the Cost of Hospitalization Below that of the Current Private ‘Non-System’.”

DECEPTION NO. 4.—“That Creation of a ‘System’ of Clinics Under Federal Aegis would be Less Expensive and More Efficient than Current Private Physician Offices.”

DECEPTION NO. 5.—“The ‘Doctor Shortage’.”

DECEPTION NO. 6.—The Cruel Hoax of Infant Mortality, “that Medical Care in U.S. is Inferior because of Higher Infant Mortality than 13 Other Countries.”

DECEPTION NO. 7.—“Doctors Overutilize Hospitals, with Unnecessarily Prolonged Hospital Stays—The Certification Fraud.”

CMS recommends the following:

1. Repeal of Section 1814 of Title XVIII of Medicare covering Certification.
2. Section 203.—Object to concealment of actual cost of the program from the public.
3. Section 211.—Object to requirement of JCAH for foreign hospitals.
4. Section 1122.—Object to establishment of compulsory Areawide Health Planning as a mechanism of rationing and creation of monopolies in health care.
5. Section 222.—Object to absence of limitations, or experimental projects, HMO's, and request public accounting and review.
6. Section 222 (a).—Object to retrospective evaluation of medical services for reimbursement.
7. Section 224.—Object to HIBAC's role in evaluation of Medicare.

STATEMENT

Mr. Chairman, I am Dr. Jose L. Garcia Oiler, Neurological Surgeon, President of the Council of Medical Staffs (American Association of Councils of Medical Staffs of Private Hospitals, Inc.). With me are Dr. Edward S. Hyman, Internist, Secretary of CMS, Dr. Kenneth Ritter, practicing psychiatrist, Vice President of CMS, Dr. Wesley N. Segre, Treasurer of CMS, and President of the New Orleans Medical Association of black physicians, and Dr. Robert Meade, second Vice President of CMS.

The Council of Medical Staffs is the national organization which represents private practitioners exclusively, with a voting membership in 15 states. We obtain the actual votes of private doctors at regularly scheduled hospital staff meetings. We believe it is time that Congress hears from those who actually take care of the sick at the bedside.

CMS holds that private practice provides the highest quality of medical care, and at the lowest cost.

As we read the 274 sections of Title II of H.R. 1, it is apparent that this law would effectively create a stifling web of regimentation under the Department of HEW affecting all facets of hospital and medical care. For such regimentation to be justified there must be an underlying assumption that private medical care is in crisis, and that the federal controls can improve the care of the sick, or lower its cost.

CMS is opposed to these provisions because they are based on invalid arguments. The following evidence is presented that there has been a deception of the American public on these basic assumptions:

DECEPTION NO. 1.—“The Cost of Medical Care is Rising Higher Than the Consumer Price Index”

The CPI is a composite index which includes goods, and services. Medical care is a *service*. When the CPI on medical care is compared over a ten year period with the CPI on services, the curves are identical. Medical care costs therefore parallel the rise in the cost of *all services* and *do not justify* the regimentation.

Medical care represents over 6.7% of the family budget. Other expenditures with a much larger share of the budget (meat, transportation, insurance) have risen equally or more than medical care.

DECEPTION NO. 2.—“The Inordinate Rise of Physicians’ Fees

The rise in physicians’ fees over a twelve year period (1965–1968), averages 3.7% per year, as compared to 4.2% rise in wages of employees covered by Social Security. Physicians’ fees have risen *less* than these wages.

A physician’s housecall averages \$13.80.¹ We ask you to compare this to the service call of your television repair man, or plumber. The average physician works 62 hours a week, and if a *union plumber* worked these hours his income would exceed that of physicians. The laborer today works fewer hours to pay for medical care than at any time in history.

DECEPTION NO. 3.—“The Imposition of a ‘System’ of Hospitals Under the Federal Aegis could Reduce the Cost of Hospitalization Below that of the Current Private ‘Non-System’ ”

An established Federal system of hospitals is the Veteran’s Administration Hospital, which has had the benefit of ripening itself under years of regimentation and control. According to the Federal Budget, 1972, the cost per patient stay at a Veteran’s Hospital is about \$1750, *far exceeding* the cost of a stay in private hospitals. The cost per stay in the Public Health Service Hospital is also higher than in private hospitals. Patients continue to stay longer in Federal hospitals and the cost of hospitalization is rising at least as rapidly as in the private sector. This evidence shows that the introduction of a federal system will not reduce costs, nor stem the rise in costs. The influence of federal requirements for paper work has already increased the cost of hospitalization in the private hospitals.

DECEPTION NO. 4.—“That Creation of a ‘System’ of Clinics Under Federal Aegis would be Less Expensive and More Efficient than Current Private Physician Offices”

From the 1972 budget figures, the cost of the average office visit to the *out-patient clinic* at a Veteran’s Hospital is \$39.50. Current figures on the cost of visits to OEO “neighborhood clinics” varies from \$40 to \$300.

DECEPTION NO. 5.—“The ‘Doctor Shortage’ ”

There are more doctors per population in the U.S. than in any country of the free world except Austria and Israel. There is one doctor per 166 soldiers in the U.S. Armed Services. Doctors are practicing in *all* but 132 counties of the U.S.² Of these 132, thirty-six of these are near major metropolitan centers. There is one new doctor graduating for each 150 increase in population. The New Orleans Public Health Service Hospital lists 138 physicians as commissioned officer personnel, with an average patient census of 307.

DECEPTION NO. 6.—The Cruel Hoax of Infant Mortality, “that Medical Care in U.S. is Inferior because of Higher Infant Mortality than 13 Other Countries”

The reason we have a “higher mortality” is because we have an *accurate system* of reporting. The other countries do *not* have an accurate system. In U.S., 97.4% of babies were born in hospitals, while in Netherlands, the “#2 country”, only 30%.³ When babies are born *in hospitals*, reporting is mandatory and *by the physician*. Death of infants delivered at home by midwives, in other countries, have varying requirements of reporting, often left to the relatives, and may never be reported.

A more reasonable standard of reference for “medical care” than “infant mortality” is the “death rate” for *treatable* diseases. The comparison with Sweden is shown in Appendix C, Fig. 1.

DECEPTION NO. 7.—“Doctors Overutilize Hospitals, with Unnecessarily Prolonged Hospital Stays—The Certification Fraud”

“Nation’s Business”, in May 1971, published an interview with Senator Russell B. Long on welfare costs. Senator Long stated “We have found that HEW estimates of costs of important programs have oftentimes been as low as 10

¹ “U.S. News & World Report”—October 25, 1971, p. 39.

² “Distribution of Physicians in the United States, 1970”—A.M.A.—Chicago, Ill.

³ “International Comparison of Perinatal and Infant Mortality: the United States and Six West European Countries”—U.S. Department of Health, Education, and Welfare—March 1967—page 13.

per cent of what a program actually costs after a year or two." Further, "The difficulty is that those people in HEW, who seem to stay there no matter who is President, have plans for the contrary. The logic of some of that scheming is almost beyond belief."; and further, "The Department of Health, Education and Welfare is spreading fraudulent propaganda about their welfare programs."

CMS would bring to your attention that the Social Security Administration has deceived the public on the matter of overutilization of hospitals by doctors. This deception was endorsed by HIBAC, the Advisory Committee on Medicare. We have pursued this matter with Social Security, and with our congressional representatives, who suggested that this be brought to a Committee of Congress.

The vilification of physicians by the SSA in accusing us of retaining patients in hospitals beyond the time they need to be there, then compounding the deception by distorting statistics on certification is beyond belief. We have exposed and documented the deception in Appendix D.

1. *We request Congress to repeal Sec. 1814(a) of the Medicare Law to remove the onerous, unnecessary, and expensive certification requirements, which have failed to reduce hospital stays and have increased costs, as well as having been the vehicle of a SSA fraud.*

We furthermore respectfully register our objections to the following amendments for the reasons indicated:

2. *Section 203 (E) (1) (i):* There is a modification in the revenue source in which any deficit will be borne entirely by another government fund. Under this system, the actual cost of the program can conceivably be hidden from the public.

3. *Section 211(b) (3):* We have serious reservations about using the standards of the Joint Commission on Accreditation of Hospitals as a measurement of the quality of medical care received in hospitals anywhere, inside or outside the United States. To use these standards as a criterion for reimbursement ignores the fact that the JOAH assesses only the environment in which care is rendered.

4. *Section 1122—Arcawide Planning:* Our experience in Areawide Health Planning indicates that this device has little to offer and is inordinately expensive. Basically, it is "a committee of passengers to fly the airplane." In four years we have wasted more money on planning than we have spent in duplicating facilities during the past century. Making review by planning bodies mandatory before approval of capital expenditures will (1) restrict competition: Competition would reduce the cost of care. (2) Will concentrate facilities in large medical centers, aggravating the problem of maldistribution of medical personnel. (3) The extent of political maneuvering for favored priority is manifest in planning bodies and has no place in the care of the sick. (4) Areawide Planning may be used by nonprofit hospitals to eliminate small proprietary hospitals. This results in a monopoly condition for non-profit hospitals and will inevitably result in higher costs. This eliminates hospitals in rural areas, which provide services which would otherwise be unavailable. (5) Federal moneys are considered "fair game" by communities, and rarely is a program involving the acquisition of more federal money vetoed. (6) Financing of *private projects* in health care usually undergoes careful evaluation by the party in question irrespective of planning. The risk of capital investment is the best assurance of careful planning.

5. *Section 222—Prospective Reimbursement Experiments:* We object to the absence of limitations for these demonstration projects and experiments. This broad authorization can establish such projects in every city and hamlet in the country and interfere markedly with the present health system. It is difficult to see how costs would be modified by providing the Secretary of HEW with a credit card on the U.S. Treasury. We recommend specific pilot programs with sound restrictions on such activities and we would like to have the privilege of review of the raw data emanating from these experimental projects.

The Section 222(a) (1) (E), pp. 191-192—dealing with absentee, third party, retrospective evaluation of which medical services were necessary in a given situation is untenable. The reviewers are actually evaluating the integrity of a record, not the adequacy of care. The threat of disallowing reimbursement unless a diagnosis unequivocally warranting hospitalization is substantiated, can seriously interfere with early diagnosis and preventive treatment.

6. *Section 224(b)*: We object to the Health Insurance Benefits Advisory Council being entrusted with a study of the reimbursement methods for physicians. Their record of accomplishment—such as in the Certification hoax cited earlier—leaves no assurance that their studies would be valid.

(a) We object to the Consumer Price Index being utilized as an "appropriate index" for physician remuneration. CPI is an estimate of the cost of all goods and services and medical care, being a service, should be compared to other services only.

Internal Medicine News

& Diagnosis News

Vol. 4, No. 14 July 15, 1971

'Deception' Charged to HEW In Medicare, Medicaid Changes

Internal Medicine News Service

WASHINGTON—The Council of Medical Staffs has confronted officials of the Department of Health, Education, and Welfare with evidence to show that deception was used in promulgating new regulations requiring earlier certification of Medicare and Medicaid hospital patients.

A showdown came at a meeting here presided over by Rep. Hale Boggs of New Orleans, the Democratic majority leader.

Dr. Jose L. Garcia Oller, president of the Council, said news releases from HEW erroneously implied that there was widespread cheating by practicing physicians in treating Medicare and Medicaid patients. He noted that data which do not exist were cited to justify a proposal to require physician certification of Medicaid patients on the 12th and 18th days of their hospital stays rather than on the 14th and 21st as regulations now provide.

The Council asked that the proposed 12- and 18-day regulation for Medicaid patients not be adopted and that a similar regulation for Medicare, which went into effect in 1970, be rescinded.

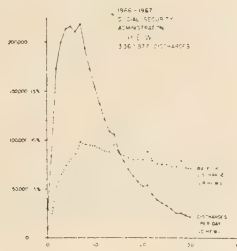
Thomas Laughlin Jr., associate commissioner of HEW's Social and Rehabilitation Service, and Thomas M. Tierney, director of HEW's Bureau of Health Insurance, said the Council's request would be studied.

The Council unsuccessfully opposed the regulation for Medicare when it was announced late in 1969. A news release from the Social Security Administration, dated Oct. 13, 1969, was challenged as being deceptively misleading.

The release said the new regulation "is expected to shorten hospital stays and thus reduce Medicare costs."

"To illustrate the potential cost savings to the program," the release continued, "Secretary (Robert H.) Finch noted that if each hospital stay by a Medicare beneficiary during 1970 is shortened by one day, Medicare costs will be reduced by approximately \$400 million."

Dr. Garcia Oller said the \$400 million figure used in the release was allowed to stand despite specific advice from Robert J. Myers, then chief actuary for HEW, that the actual savings would not be more than \$5 million.



Vertical axis indicates number of patients discharged on the left column and discharge ratio on the right column. Horizontal axis indicates day of hospitalization since admission.

The curve shows 109,053 patients were discharged on the 13th day and 106,761 on the 14th day. This actual drop in discharges is a small shoulder in the curve of discharges (HEW), but becomes a peak in HEW's "discharge ratio." The tiny rise at 21 days and the unnoticeable rise at 28 days are also amplified into peaks by HEW and ascribed to "certification." Yet there is no certification on the 28th day, a Council spokesman notes.



Vertical axis indicates discharge ratio and the horizontal axis indicates days in hospital for the period October, 1966, to June, 1967.

The HEW claim of \$400 million savings is fraudulent, says a spokesman for the Council of Medical Staffs. The correct estimate would be \$4.17 million, at \$100 per diem. Assuming the peaks of the ratio of discharge at 14 and 21 days are caused by certification and assuming that peaks are the termination of "unnecessarily prolonged hospital stays," HEW claimed to save \$400 million by pushing these peaks back through a change in certification dates. If the 14 day peak is moved 2 days and the 21 day peak is moved 3 days, the saving would be 41,743 patient days per year nationwide. At a generous \$100 per diem this amounts to \$4.17 million, not \$400 million as claimed by HEW. HEW was aware of this error when the claim was made, the Council spokesman says.

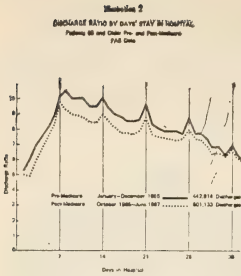
Mr. Myers calculated that to shift the peak discharge rate to the 12th and 18th days "is to reduce the average days of hospitalization by discharge, by .014 days, which represents a savings of \$5 million per year."

The 1969 HEW release contained the statement:

"Data on length of stays in hospitals under the (Medicare) program show that the number of discharges rises significantly on the 14th day and again on the 21st day," Secretary Finch said. "Since there is no apparent medical reason why discharges should peak on these days, it seems reasonable to conclude that the requirement for certification and recertification on certain days is in itself a factor contributing to the larger number of discharges on such days."

"We expect that a reasonable shortening of the certification periods will result in some decrease in the number of unnecessarily prolonged hospital stays."

Dr. Garcia Oller said a reader of this release would infer that practicing physi-

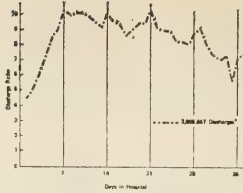


PAS data shown above establishes that the insignificant peaks of discharge ratios antedate Medicare and could have no relation to the requirement to certify.

Patients were cheating the government by holding patients in hospitals without medical cause.

In addition, he cited HEW's own statistics showing that in the period October, 1966-June, 1967, the discharges of Medicare patients actually dropped from 109,053 on the 13th day to 106,761 on the 14th. There were 52,924 discharges on the 20th day, 53,614 on the 21st.

He stated that a discharge ratio invented by HEW to amplify minor deviations in the curve of discharges showed insignificant peaks on the 7th, 14th, and 21st days. HEW attributed these peaks to the Medicare requirement for certification and regarded this as proof that the regulation was effective in terminating "unnecessarily prolonged hospital stays." But, the Council noted, figures compiled by the Professional Activity Study of the Commission on Professional and Hospital Activities showed identical peaks for patients 65 years and older even before Medicare was established. This proves that the peaks were not the result of Medicare certification, he said. SSA did not collect this control data before making its assertion.



Certification change in 1970 fails to move discharge ratio peaks. On January 1, 1970, Medicare regulation was changed to require certification to the 12th day and recertification to the 18th day. If successful, the regulation would have moved the 14- and 21-day peaks to the 12th and 16th days. As shown, there was no change in the discharge pattern. Yet on March 30, 1971, HEW claimed that the Medicare regulation had "reduced hospital stays significantly," the Council spokesman notes.

"Thus the regulation really had no effect, and the rationale does not support the regulation," Dr. Garcia Oller commented.

An HEW news release on March 30, 1971 announced the department's intention to extend the 12- and 18-day regulation to Medicaid. A paragraph in the release read:

"Experience with Medicare has shown that requiring certification or recertification by physicians reduces hospital stays significantly," Federal Social and Rehabilitation Administrator John D. Twinn said. "Applying this requirement to Medicaid can cut its costs without lowering the quality of care. Thus we can provide for needed medical care, without unnecessary costs to the taxpayers."

The Council asked Rep. Boggs to obtain the data on the experience with Medicare which the news release cited, and was told by the Congressman: "The data used to justify the proposed regulations relative to certification and recertification of Title XIX... is the same as

that developed by the SSA in 1969."

"HEW said the experience with Medicare justified the new regulation for Medicaid, yet the department can cite no data to back up the claim," said Dr. Garcia Oller. Data on the effect of new regulation do exist and have been published. A PAS study on a comparable number of Medicare discharges has shown that there has been no change in the 14- and 21-day discharge ratio peaks in spite of the change in certification to the 12th and 18th days in January, 1970.

By HEW's own yardstick, therefore, the Medicare experience with the January, 1970, regulation does not justify the claims of any savings or benefit from the certification regulation made in the March 30, 1971, HEW news release, Dr. Garcia-Oller said.

State Sen. William J. Guste Jr. of New Orleans, who made the Council's presentation at the Washington meeting, asked that the Medicaid regulation not be put into force because it is "unwarranted, unnecessary, ineffectual and against the

public interest."

The Council was represented by members of its executive committee, including Dr. Garcia Oller; Dr. Kenneth Ritter, vice-president; Dr. Robert Meade, vice-president; Dr. Edward S. Hyman, secretary; and Dr. Wesley Segre, treasurer.

HEW officials present included Mr. Laughlin; Mr. Tierney; Hugh Johnson, assistant SSA commissioner; Al Richter and the Rev. Homer Jolley, of the Medicaid administration.

Aides of Louisiana senators and representatives also attended, along with Rep. Boggs himself.

The Council of Medical Staffs lists a membership of more than 20,000 practicing physicians on the staffs of 300 hospitals in a dozen states. There are chapters in California, Louisiana, Michigan, Ohio, Texas, Florida, New Jersey, Kansas, Oklahoma, Minnesota, Nevada, New Mexico and Rhode Island.

The CHAIRMAN. The next witness will be Dr. Paul W. Spear, chairman of the Physicians Forum.

Is Mr. Spear here?

We will then call the next witness, Miss Margaret Ewing.

STATEMENT OF MARGARET EWING, ATTORNEY, NATIONAL HEALTH AND ENVIRONMENTAL LAW PROGRAM, UNIVERSITY OF CALIFORNIA, LOS ANGELES, ACCOMPANIED BY HARVEY MAKADON, HEALTH LAW PROJECT, UNIVERSITY OF PENNSYLVANIA LAW SCHOOL

Miss EWING. Good afternoon, Mr. Chairman. My name is Margaret Ewing. I am an attorney with the national health and environmental law program at the University of California. I would like to introduce Mr. Harvey Makadon, on my right, from the health law project at the University of Pennsylvania Law School. Both OEO-funded health law programs helped to prepare the detailed analysis of the health care provisions of H.R. 1 that is attached to my written testimony which has been submitted for the record.

I will not try to read that testimony this afternoon but would like to give a shorter statement highlighting some of its major points.

Before doing so, however, let me explain that the health law program at UCLA is an OEO legal research center which provides backup services for legal services attorneys throughout the country in matters relating to health care. It is against this background of experience with legal problems arising under the present medical assistance programs that I would like to comment on H.R. 1.

Few of us would disagree that great efforts must be made to control the costs of the States' medicaid programs. We are well aware that the cost of this program has gone far beyond the most liberal estimates made at the time of its enactment in 1965 and that it is a tremendous financial burden for the States. However, we do not believe that the extraordinary cost of the program is due to the fact that people who can afford to buy medical care are getting it under medicaid or that persons eligible for medicaid are getting more services than they need. Rather, we believe the costs incurred in the medicaid program are a reflection of the spiraling health care costs experienced by the country as a whole. Therefore, we believe H.R. 1 should deal with this problem by developing ways in which costs paid to providers can be kept down. It should not, as it presently does, restrict existing medicaid benefits to recipients.

Specifically, we suggest that H.R. 1 be amended in three respects to insure that persons who truly need medical assistance be entitled to receive it after the passage of H.R. 1.

First, section 209 of the bill should be revised to provide that all recipients of cash assistance under the new Title XX and XXI programs would be automatically eligible for medicaid. This would retain the concurrent relationship between the cash assistance and medicaid programs which presently exists in Title XIX and would eliminate some anomalous situations which will otherwise result after the passage of H.R. 1. As it is now drafted, H.R. 1 would permit some persons currently eligible for AFDC and medicaid to become ineligible for medicaid after the passage of H.R. 1 even though they would continue to qualify for cash assistance.

In addition, all intact families with a working father receiving assistance under the Title XXI program would be excluded from a State's basic medicaid program after H.R. 1. This would be true despite the fact that their financial need has been determined by the State to be as great as that of the needy family as defined in the act. As a result of provisions which permit eligibility for cash but not medical assistance, the work incentive carefully built into the cash assistance program for families will be removed. Instead of being able to keep \$1 of disposable income for every \$3 of earned income, such families will be required to spend that dollar on medical care before they will become eligible for medicaid.

This will act as a significant disincentive to earn income above the medical assistance levels. This disincentive would be prevented if concurrent eligibility for cash assistance and medicaid were retained by H.R. 1.

Second, we suggest that H.R. 1 be amended to remove an even greater disincentive for work which exists in the present medicaid law. Under

the present law, in a State which has a minimal medicaid program, one which includes only cash assistance recipients, and not the medically indigent, a person who earns \$1 over the medicaid income maintenance level finds that he loses all entitlement to medicaid benefits no matter how great his medical expenses may be. If he is \$50 over income, he will not become eligible for medicaid if he incurs \$50 worth of medical expenses as he would under the flexible income test required in States which have a program for the medically indigent. He cannot spend his way down to medicaid eligibility because he is disqualified by the fact that his income is too high.

Since most people can anticipate a significant amount of medical expenses in a year, and fear greater ones, there is a real disadvantage to earning income above the medical assistance levels. We strongly believe this work disincentive is unfair and destructive and should be removed by an amendment to H.R. 1 which would make the flexible income provision of section 1902(a) (17) applicable to States which have only a minimal program.

There are about 22 such States.

Third, we believe the provisions in H.R. 1 for enrollment fees from persons eligible for medicaid should be removed. As the bill now reads, States would be permitted to charge a nominal deductible fee for optional services to cash assistance recipients and would be required to charge an enrollment fee related to income to the medically indigent. Such cost sharing provisions cannot be justified as revenue measures since their administration may well cost more than the payments themselves. They are said to be required to control overutilization. We submit that there is no basis for the assumption that the poor overutilize medical care facilities. Studies cited in the appendix to my written testimony show the contrary. What these payments may well succeed in doing is deterring the poor from seeking exactly the kind of medical care they need most and that is least expensive to provide—preventive care and early treatment.

We would, therefore, urge the committee to reject section 208 of the bill.

Finally, I would like to suggest that this committee consider adding an amendment to H.R. 1 that would permit the Federal Government to establish standards governing the quality of hospital care which is purchased through the medicare program. The need for better regulation of hospital services is especially acute in the Nation's State, county and municipal hospitals which have traditionally served the poor.

The quality of care provided to indigents and to medicaid and medicare beneficiaries in these overcrowded and underfinanced hospitals is often demonstrably below that generally available to self-paying patients. In some cases it is below any acceptable standard of competence; nevertheless, the Federal Government continues to reimburse these hospitals for rendering substandard services to persons on medicare and medicaid. This is because HEW is bound by statute to certify as a provider any hospital accredited by a private body representing the Nation's hospital administrators and doctors—the Joint Commission on the Accreditation of Hospitals.

About 94 percent of the country's State, county and municipal hospitals with over 100 beds, eligible to receive medicare payments, are accredited by the Joint Commission.

Under section 1861 of the Medicare Act, the Secretary of HEW is instructed to promulgate standards to protect the health and safety of beneficiaries in hospitals. This authority is almost completely undermined, however, by two additional provisions. The Secretary is prohibited from promulgating standards higher than comparable standards established by the JCAH and any hospital accredited by the JCAH is deemed to have complied with the Secretary's conditions of participation.

The Joint Commission on the Accreditation of Hospitals is a private corporation whose governing board is made up of representatives from the American Hospital Association, the American Medical Association, the American College of Surgeons and the American College of Physicians.

After its accreditation program became part of the medicare certification process, the Joint Commission revised its standards and last year put into operation new standards which are a significant departure from both the philosophy and content of its former standards. Thus, section 1861 now prohibits the Secretary from promulgating standards higher than comparable standards of which Congress was absolutely unaware when it passed title XVIII.

Being tied by legislation to comparable standards, HEW has promulgated conditions of participation for hospitals which are a paraphrase of the Commission's standards. In addition, HEW maintains that it is without authority to establish standards in areas such as outpatient care in which the Commission has established no comparable standards and without authority to inspect any hospital so long as its JCAH accreditation remains in effect.

The Joint Commission has repeatedly stated that it does not consider itself a policing body but, rather, a private consulting service for hospitals whose findings are confidential. Not only will the JCAH not make its hospital inspection reports available to the public, they will also not make them available to the Social Security Administration. We believe this seriously hampers the Administration's ability to evaluate the services purchased through the medicare program.

We submit that however valuable its services may be as a private consultant, an organization made up exclusively of representatives from about 6,000 of the Nation's 7,000 hospitals and the predominant medical associations should not be given authority to determine the quality of hospital services which the Government will purchase from them.

The health law program believes that such a system is an improper if not unconstitutional delegation of governmental authority to a private body. We therefore suggest that the committee consider amending H.R. 1 to provide that the Secretary shall be fully empowered to develop and apply standards of competence to hospitals receiving title XVIII reimbursement; in this way the medicare program could be useful in bringing about a higher level of hospital care available to the poor.

In conclusion, I would like to urge once more that the committee amend H.R. 1 so as not to restrict the present medicaid program but to use the leverage that exists in the medicare and medicaid programs to control the costs of medical services and raise the quality of medical care available to the poor and ultimately to us all.

Thank you very much for the opportunity to appear here today.

The CHAIRMAN. Thank you very much.

(The prepared statement and attachments of Miss Ewing follow. Hearing continues on page 2725.)

STATEMENT OF MARGARET F. EWING ON BEHALF OF THE NATIONAL HEALTH AND ENVIRONMENTAL LAW PROGRAM

My name is Margaret Ewing. I am an attorney with the National Health and Environmental Law Program, at the University of California at Los Angeles. The Health Law Program is an OEO funded research center established to assist legal services attorneys in health related legal matters. The program has been in operation for about two years and has done extensive research in many areas, including eligibility of the indigent for Medicare and Medicaid, and legal mechanisms for maintaining high quality medical care. It is against this background of experience with the legal problems encountered under the present government health programs that I would like to comment on H.R. 1's health care provisions, on behalf of the Health Law Program.

First, I will briefly summarize the detailed discussion of the bill's health care provisions which appears in the analysis appended to my testimony. Second, I would like to direct the committee's attention to two related legal problems encountered by the poor in their search for good health care—the obligation of tax exempt hospitals to serve the indigent and the quality of hospital care purchased through the Medicare and Medicaid programs.

With the exception of increases in deductibles and copayment provisions noted in the appendix, we approve of H.R. 1's provisions dealing with Medicare. Those provisions which we support would extend benefits to persons previously uncovered, would use the leverage of Medicare and Medicaid payments to stimulate comprehensive health care arrangements and enforce planning decisions and would seek to control the charges of providers under Medicare.

MEDICAID PROVISIONS

However, most of the bill's provisions dealing with Medicaid, would either directly restrict that program or permit the states to cut it back. We oppose these provisions. As passed by the House, the bill would exclude some families now eligible for Medicaid benefits, would create work disincentives for some persons receiving cash assistance, would discourage eligible persons from using Medicaid services, and would permit the states to eliminate whole areas of service from their programs, such as dental care, eye glasses, prescription drugs.

We are aware that the cost of the Medicaid program has gone far beyond the most liberal estimates made at the time of its enactment in 1965, and that it is a great, unanticipated financial burden on the states which must bear about half its cost. Nevertheless, denying poor people medical care of which they are in need is an inhumane and, in the long run, expensive way in which to reduce the costs of the program.

We believe that the extraordinary expenses encountered are attributable largely to spiraling health care costs experienced by the country as a whole rather than to a program too broad in its scope and coverage. Therefore, we suggest that the committee eliminate those provisions of H.R. 1 which would restrict Medicaid benefits and concentrate its efforts instead on controlling costs paid under the program to providers of service.

1. Medicaid eligibility criteria narrowed

H.R. 1 would restrict the Medicaid program in three ways. First, Section 209 would result in a tightening of eligibility criteria with the result that many existing and potential beneficiaries will be excluded from the program. Some families now eligible for XIX benefits would be excluded after enactment of H.R. 1 even if they were eligible for OFF or FAP, because they will be denied the full benefit of FAP income disregards in determining their Medicaid eligibility.¹ Intact families who become newly eligible for cash benefits under FAP and OFF would be excluded from the program altogether.² Some AFDC related bene-

¹ Section 209 (c).

² Section 209 (a).

ficiaries eligible for assistance by virtue of a higher FAP level would not be eligible for Medicaid because the states are permitted to maintain 1971 medical assistance level.³

Furthermore, rather than eliminating a disincentive to earn income above medical assistance levels in states with a minimal program, the bill preserves this work disincentive and adds another one. The ironic situation that results from eligibility changes made by H.R. 1 is that many families which are determined to be in need of assistance from the OFF or FAP programs will be ineligible for Medicaid, until such time as they incur medical expenses up to the amount by which their income and assistance payments exceed the state's medical assistance standard. There is a disincentive, then, for such families to earn money above the medical assistance level since they know that each dollar earned must be spent on medical care before the family will again be entitled to have Medicaid cover its remaining medical expenses. These expenses would have been covered by Medicaid if they had not earned the additional dollars. Thus, the assistance that Congress gives through FAP and OFF with one hand is taken away with the other hand by not requiring automatic Medicaid eligibility for all persons receiving cash assistance.

2. Enrollment fees and co-payment provisions added

Second, H.R. 1 would discourage eligible persons from seeking benefits under it. The bill would require a "nominal" enrollment fee from persons receiving cash assistance seeking services other than the five basic services, and an enrollment fee based on income for all services from the medically indigent. (Section 208) In addition, the bill removes prohibition in the present law against deductibles and co-insurance not based on ability to pay. These provisions for enrollment fees, premiums, deductibles and co-insurance payments are to be exacted from persons defined by the states to have funds sufficient only to meet their needs for food, shelter and clothing. Thus, they necessarily require the diversion of funds from these purposes to obtain medical care. Since the administration of these income related payments may well cost more than the amount of the payments themselves, they cannot be justified as revenue provisions. Rather, the provisions are said to be necessary to prevent "overutilization" and to encourage "cost-consciousness".

We respectfully submit that there is no basis for the assumption that the poor overutilize medical facilities. In fact, several reliable studies cited in the appended analysis show quite the opposite. The use of compulsory patients payments to control utilization ignores the fact that, except for the initial visit to the doctor, it is the physician and not the patient who orders such services as X-rays, lab tests, drugs and subsequent visits, which amount to about 90% of total services. We believe that the effect of enrollment fees and deductible requirements will be to discourage poor people from seeking exactly the kind of care that they need most and that is least expensive to provide—preventive care and early treatment. The indigent mother who decides not to take her child with a cough to the doctor in order to keep the enrollment fee or deductible payment in her food budget may well present the child at the emergency room some days later to be hospitalized with pneumonia. Such an approach to the provision of medical care for the poor is penny wise and pound foolish.

3. Prohibitions against state cut backs removed

Third, H.R. 1 would permit the states to cut back on the persons and services included in their Medicaid programs. Section 209 would permit a state to lower its income eligibility level for the optional medically-indigent program to one only slightly above its cash assistance level. It would allow the states to cut back on all but the five mandatory services (including dental care, and eyeglasses) without HEW approval. (Section 231) And it would remove the requirement that states make efforts to provide comprehensive medical care to all the needy by July 1, 1977. (Section 230) In light of the financial pressures faced by most states at this time, it is very likely that the states will take advantage of this new authority to cut back their Medicaid programs. The bill should prohibit this being done in ways which will destroy the states' ability to render comprehensive care to beneficiaries as Congress intended.

We strongly urge, therefore, that Congress amend H.R. 1's provisions in the following ways: First, the bill should provide, as does the present law, that

³ Section 209 (d).

all persons receiving cash assistance under FAP and OFF are automatically eligible for the state's minimum Medicaid program. Second, persons with income in excess of the medical assistance levels in states which have a minimal Medicaid program (for cash assistance recipients only) should be permitted to become eligible when they have incurred medical expenses in the amount by which they are over-income. Third, states should not be permitted to exclude persons now eligible for Medicaid from their programs after the enactment of FAP and OFF.

The consequence of the restrictive Medicaid provisions now in H.R. 1 will be that many families now eligible for benefits will join those poor persons without categorical attributes, largely single persons and married people under 65, without children, who must seek free or below cost medical care from local public health facilities or from private charities. In addition, Medicaid beneficiaries will have to look to the same sources for the services cut out of state plans. Therefore, this Committee should be aware that, for reasons I will discuss, some private medical facilities are less likely to provide free service to the non-Medicaid poor today than they were prior to the development of the program in 1965. In addition, public health facilities, upon which the non-Medicaid poor must rely, such as municipal and county hospitals, are already overburdened and generally offer medical care of considerably lower quality than is generally available from private hospitals.

ACCESS OF THE POOR TO TAX EXEMPT HOSPITALS

More than half of the nation's short term hospitals are private non-profit hospitals which qualify under Section 501(c) (3) of the Internal Revenue Code as tax exempt charitable institutions. Prior to 1969, these hospitals were required by an Internal Revenue Ruling to provide charitable and below cost care to the extent of their financial ability in order to maintain their tax exempt status. (Rev. Ruling 56-185) In 1969, a House amendment to the tax reform bill of 1969 (H.R. 13270) would have removed this obligation from charitable hospitals. The Senate, however, and this Committee rejected the amendment and the rejection was accepted by the House conferees. Several weeks before this Committee reported out the House bill, the Internal Revenue Service withdrew its 1956 ruling requiring free care and substituted one which had the same effect as the House amendment. (Rev. Ruling 69-545) It permits hospitals to maintain their tax exempt status so emergency care to all comers. Thus, although determined to be charitable, hospitals are required to offer no services except those for which they will be paid in full. In deleting the amendment to this effect from the House bill, this Committee stated that it desired to consider the issue in the context of Medicare and Medicaid.

The Medicaid and Medicare programs have been in operation for even years now. It is time to determine whether, as we have reason to believe, private tax exempt hospitals have eliminated or decreased the amount of free care they provide to the poor. In the face of mounting pressure to keep inflating hospital charges down, and perhaps relying on the mistaken notion that together Medicaid and Medicare cover the basic medical needs of all of the poor, it would be surprising if many hospitals have not referred or transferred indigent patients to public health hospitals that they might otherwise have undertaken to treat. A law suit brought recently by eight indigents and five organizations charges eight tax exempt hospitals with a refusal to provide any free care at all to indigents. In addition, there are tax exempt hospitals which have refused to become certified as Medicaid providers and hospitals which are certified but which strictly limit their services to Medicaid patients through various means. We suggest that this Committee investigate this problem and seriously consider endorsing a legislative repeal of the 1969 ruling.

JCAH AND THE QUALITY OF HOSPITAL CARE

Finally, I would like to suggest that this Committee consider adding an amendment to H.R. 1 that would permit the federal government to establish standards governing the quality of hospital care which is purchased through the Medicare and Medicaid program. The need for better regulation of hospital services is especially acute in the nation's state, county and municipal hospitals. Many exist in antiquated facilities, are understaffed, serve a larger population than intended and are under-financed because of the general squeeze on state and municipal budgets. The result is that the quality of care provided to indigents and to Medicaid and Medicare beneficiaries in such hospitals is demonstrably below that

generally provided self-paying patients. In some cases, it is below any acceptable standard of competence. Nevertheless, the federal government continues to reimburse these hospitals for rendering substandard services to persons on Medicare and Medicaid because HEW is bound by statute to certify as a provider any hospital accredited by a private body representing the nation's hospital administrators and doctors—the Joint Commission on the Accreditation of Hospitals.

In 1965 when the federal Medicare program was adopted Congress chose to look to JCAH accreditation as the primary means of certifying a hospital as a provider. Under Section 1861 of the Medicare Act, the Secretary of HEW is instructed to promulgate standards to protect the health and safety of beneficiaries in hospitals. (42 U.S.C. 1395x(e)(8)). This authority is almost completely undermined, however, by two additional provisions. The Secretary is prohibited from promulgating standards higher than comparable standards established by the JCAH (42 U.S.C. 139x(e)(8)) and any hospital accredited by the JCAH is deemed to have complied with the Secretary's conditions of participation. 42 U.S.C. 1395bb.)

The Joint Commission on the Accreditation of Hospitals is a private corporation whose governing board is made up of representatives from the American Hospital Association, the American Medical Association, the American College of Surgeons and the American College of Physicians. There are no governmental or consumer oriented members on the Commission's board. The JCAH was created in 1951 to carry on the program begun by the American College of Surgeons in 1919 of accrediting hospitals in order to better appraise the experience of doctors applying for membership in the College. This accreditation program gained in stature and scope until it became accepted as a professional seal of approval voluntarily sought by hospitals. The Joint Commission now accredits 76% of all short-term general hospitals certified as Medicare providers and 94% of all such public hospitals with over 100 beds.

After the Medicare program became law, the Joint Commission discarded the standards which had been in effect at the time Congress enacted the provisions referred to above, and set about creating new quality standards for hospitals. These were put in operation last year and are a significant departure from both the philosophy and the content of its prior standards. Thus, section 1861 of the Medicare statute prohibits the Secretary from promulgating standards higher than comparable standards of which Congress was absolutely unaware when it passed Title XVIII. Being tied by legislation to "comparable" JCAH standards, the Secretary has promulgated conditions of participation (applicable to hospitals not accredited by the Joint Commission) that are a paraphrase of the Commission's standards. In addition, HEW maintains that it is without authority to promulgate standards in areas, such as out-patient care, in which the Commission has established no comparable standards.

The standards established by the Joint Commission are stated in terms of principles which are very vague and which leave enormous room for discretion in their application. For instance, the standards require that the staffing of a hospital emergency room "shall be related to the scope and nature of the needs anticipated and the services offered." These broad standards admittedly permit the JCAH to make judgments concerning a hospital's ability to upgrade its services in response to the threat of the loss of accreditation. In applying its standards, the Joint Commission admits that it has no level for compliance beneath which a hospital would necessarily be denied accreditation. The Joint Commission accredits hospitals for two year periods during which no on site inspections are made by the Commission. Each hospital is informed several months prior to the Commission's on site inspection survey and has ample time to prepare for it. HEW has concluded that under the present law it has no authority to inspect a hospital to determine the quality of patient care being provided so long as the hospital's JCAH accreditation remains in effect.

The inadequacy of the JCAH accreditation process to bring about necessary improvements in patient care is well illustrated by a recent case in the District of Columbia. In 1970, several senior citizens groups from the District of Columbia, composed largely of Medicare beneficiaries, and the house staff physicians of D.C. General Hospital, the city's hospital for indigents, requested an interview with the surveyors of the Joint Commission inspecting the hospital. These groups protested among other things the inadequacy of D.C. General's emergency room staff, which resulted in patients waiting many hours to be seen. In addition, they presented evidence that the hospital suffered from severe deficiencies in nursing

personnel, record keeping, laboratory competence and drug supplies. The surveyors heard the evidence but refused to comment on it, refused to make any findings with regard to the allegations made, and refused to make their report of the survey available to the complainants. The JCAH subsequently renewed the hospital's accreditation without explanation.

After the death of a patient who had waited seven hours to be seen in the emergency room some months later, the same citizens' groups instituted a law suit against the hospital in which a United States District Court Judge issued an order for preliminary injunction finding the staffing of the hospital's emergency room inadequate.⁴ He ordered the hospital to keep three licensed physicians on duty in the emergency room at all times—triple the number previously on duty during some shifts when JCAH accredited the hospital.

Not only will the Joint Commission not make its reports on hospital compliance available to the public, it refuses to make them available to the Social Security Administration which must therefore rely on the bare fact that the Commission has accredited a hospital in certifying it as eligible to receive Medicare reimbursement. This seriously obstructs Social Security Administration efforts to evaluate the services purchased through Medicare. The Joint Commission has repeatedly stated that it does not consider itself a policing body, but rather a private consulting service for hospitals whose findings are confidential.

We submit that, however valuable its services may be as a private consultant, an organization made up exclusively of representatives of the American Hospital Association, to which 6,090 of the nation's 7,123 hospitals belong, and the predominant medical associations has an institutional interest in establishing accreditation standards that can be met by as many hospitals as possible who seek to be certified for Medicare reimbursement. Such an organization should not be given authority to determine the quality of hospital services for which the government will pay. Yet that is the effect of Section 1861. for JCAH standards have been imposed as ceilings for hospitals participating in Medicare. These are not minimum standards but mandatory maximums—the requirements of the Secretary of HEW “may not be higher * * *

The Health-Law Program believes that such a system in effect provides *no* legally enforceable minimum standards for the quality hospital services to be purchased with federal funds, and is an improper, if not unconstitutional, delegation of government authority to a private body. We, therefore, suggest that the Committee consider amending H.R. 1 to provide that the Secretary shall be fully empowered to develop and apply standards of competence to hospitals receiving XVIII reimbursement. Such standards should be applied in the Title XX program as well.

In conclusion, I would like to thank the Committee for this opportunity to appear before you today and to urge once more that you amend H.R. 1 so as not to restrict the present Medicaid program but to use the leverage that exists in the Medicare and Medicaid programs to control the costs of medical services and to raise the quality of medical care available to the poor. Thank you very much.

H.R. 1: MEDICARE AND MEDICAID PROVISIONS

(A comment on amendments to the Medicaid and Medicare Program contained in H.R. 1) *

Provisions Which Should Be Amended in the Interest of the Poor

I. COST SHARING UNDER MEDICAID AND MEDICARE. §§ 208 AND 205

A. Section 208 Medicaid

Section 208 sets out new requirements for cost sharing under Medicaid. It provides that deductions or cost sharing may be imposed on cash assistance recipients in “nominal” amounts for services other than inpatient and outpatient hospital services, physician services, skilled nursing services, home and health care

⁴ *Greater Washington, D.C. Area Council of Senior Citizens, et al. v. Walter Washington, et al.*, U.S. Dist. Ct. D.C. No. 275-71 (Sept. 28, 1971).

*The National Health and Environmental Law Program, Los Angeles, Calif., [and] The University of Pennsylvania Health Law Project, Philadelphia, Pa. [with the cooperation of] The N.L.S.P. Center on Social Welfare Policy and Law, New York, N.Y.

services, and laboratory and x-ray services. With regard to the medically needy, § 208 provides that a state *must* charge a premium or enrollment fee related to income and, in addition, removes all prohibition against the imposition of further deductibles and coinsurance which would not have to vary by level of income. Although present law allows income related cost sharing (except with respect to inpatient hospital services provided to cash recipients), up until now cost sharing has not been widely imposed. HEW regulations have defined the income of cash assistance recipients as necessary for maintenance and work incentives, and therefore not available for cost sharing charges. This has meant that, in effect, cost sharing could be imposed only on the medically needy. But because cost sharing programs where costs are related to means are administratively infeasible,¹ only one state, New York, has chosen to institute such a program. Section 208 attempts to avoid some of these problems by making income related cost sharing for the medically needy mandatory, and by further allowing cost sharing which is not income related.

The rationale behind § 208 is, as stated in the Ways and Means Committee Report on H.R. 1, "to discourage possible unnecessary overutilization and to encourage cost-consciousness on the part of those covered under Medicaid."² Yet there is no evidence whatsoever that the poor are overutilizing available health services. If anything, the poor underutilize services. General experience throughout the country indicates that when the financial barriers which keep the poor from consuming medical services are removed, the poor tend to utilize medical services only to the same extent as the non-poor.

Since 1965 the Office of Economic Opportunity has been supporting neighborhood health centers, one of whose basic objectives has been to eliminate any beneficiary cost sharing. In reviewing utilization experiences of the O.E.O. health program, studies have documented the fact that the neighborhood health center enrollee averages 4-5 visits to a physician per year compared to the national average of 4.5 annual visits per person.³ Another O.E.O. health grantee, recently transferred to the Department of H.E.W., is the Kaiser Foundation Health Plan in Portland, Oregon. Integrating a population of 6,000 poor individuals into approximately 120,000 nonpoor plan enrollees, Kaiser has found that by eliminating copayment, deductibles, and all other forms of personal contribution for the poor, there is no overutilization of total medical services. A study of the Kaiser experience indicates that the poor and the non-poor make similar aggregate use of physician services.⁴ On the average each member of the O.E.O. population visited a physician 3.9 times per year, while the rate of visits for the whole health plan membership was 4.1. Thus, based on the experience of the O.E.O. health programs which now provide medical and health services for approximately 1 million poor people, removing financial barriers to health care does not appear to cause excessive overutilization of medical services.

Furthermore, the present Medicaid experience, operating without financial participation from the beneficiary, has not exhibited a tendency for the poor to overutilize medical care. Although the 1968 national physician utilization rate is 4.2 engagements per year, current Medicaid experience in California is only 2.0 per beneficiary.⁵

Even were this not true, and excessive utilization was a problem amongst the poor, it is essential to remember that implementing cost sharing provisions to reduce unnecessary utilization does not reach the basic issue: the impact of physician decision making. Dr. Milton Roemer, Professor of Medical Care Administration at the University of California at Los Angeles, has stated:

"It must be recognized that the great majority of services rendered in a medical care program are decided upon by the physician and not the patient. The initial medical contact is the patient's decision, but almost every other service after this—subsequent visits, hospitalization, prescribed drugs, laboratory or

¹ Staff Report, Senate Committee on Finance, Medicare and Medicaid Problems, Issues and Alternatives, 91st Cong., first sess., 129-130 (1970).

² H.R. Rep. No. 231, 92d Cong., first sess., p. 74.

³ Sparer, G. and Strauss, "Basic Utilization Experience of O.E.O. Comprehensive Health Services Projects" Presented Before the Research on Health Planning Processes and Techniques Section, American Public Health Association (October 29, 1970).

⁴ Colombo, *Supra*, n. 7 at 647.

⁵ *California Medical Assistance Program Services and Payment Reports*, California Department of Health Care Services, July 1969-July 1970; *Current Estimates From the Health Interview Survey*, United States, 1968, Vital Health Statistics Series 10, No. 60, National Center for Health Statistics.

x-ray examinations, physiotherapy, etc.—is ordered by the doctor. For most of these services, especially hospitalization (in the American setting, though not in Europe), the physician stands to gain additional earnings. In terms of total costs, the services which are patient-decided probably account for about 10 per cent, while the doctor-decided services account for 90 per cent. It follows that various cost sharing or "co-insurance" devices used to inhibit patient demand for medical care in organized programs can have very little effect on utilization rates."⁶

It should be clear that it makes little sense, except in terms of sheer cost-saving, as opposed to control of utilization, to cut back on overutilization of health facilities amongst the needy. Yet even if this were not the case, there should be no imposition of cost sharing or deductibles, however "nominal", on the poor. For when a person is very poor, almost any sum of money has concrete meaning. When such a person is made to "stop and think" about going to the doctor, which is what cost sharing intends; it means that he is made to consider whether spending money on medical services is worthwhile in light of his food, housing, carfare, and other basic needs. The poor of this nation must not be made to choose amongst such fundamental necessities, and to this end it is recommended that § 208 be amended to eliminate all cost sharing provisions under Medicaid.

B. Section 205 Medicare

Section 205 of H.R. 1 would affect Medicare beneficiaries in much the same way that § 208 would affect people receiving Medicaid. Even though it also extends coverage under Medicare from a maximum of 150 days to a maximum of 210 days (120 days of which can be used only once in a lifetime), it imposes a co-payment on those staying in the hospital over 30 days. Whereas presently one has to pay a co-payment only after receiving inpatient hospital care for 60 days, § 205 requires a co-payment of \$7.50 a day for each day of hospital care over 30 and under 61, a requirement that can add as much as \$225.00 to an individual's hospital bill.

The Ways and Means Committee explains this provision in much the same way it explained § 208. The Committee report states: "experience indicates that about 10 per cent of the hospitalized aged use more than 30 days of hospital care during a benefit period and it may well be that in some of those cases care beyond 30 days is really not needed."⁷ Addition of the co-payment is intended to cut down on this utilization, yet the discussion above on § 207 would apply here as well. At least as far as the needier elderly are concerned, a co-payment might well serve not to control unnecessary utilization but, if anything, to seriously restrict necessary hospital care. Going beyond the changes made in § 205, this is also true of the existing deductible and co-insurance provisions as they apply to the needy elderly.

It is recommended that § 205 be amended to repeal or waive all co-insurance and deductible requirements for the needy elderly. The needy elderly should be defined for purposes of this amendment as those with income below the Social Security Administration's Poverty Index.⁸

⁶ Roemer, M. I., "Diverse Methods of Paying for Medical Care and Their Effects on the Services Provided," Selected Papers on Health Issues in California, May 1971.

⁷ H.R. Rep. No. 231, 92d Cong., first sess., p. 71.

⁸ Family size:

	Income
1	\$2,002
2	2,587
3	2,948
4	4,070
5	4,791
6	5,376
7 or more	6,618

The Social Security Administration's Poverty Index is based on the U.S. Department of Labor's Economy food plan, adjusted for changes in the Consumer Price Index through May 1971. Dept. of Labor, BLS Report No. 237-38. BLS Consumer Price Index, August 1971. The inadequacy and bare subsistence nature of the SSA Poverty Index has been widely recognized. See Orshanski, *Counting the Poor: Another Look at the Poverty Profile*, Soc. Sec. Bull., vol. 28, No. 1, p. 3 (Jan. 1965); Orshanski, *The Shape of Poverty in 1966*, Soc. Sec. Bull., vol. 31, No. 3, p. 4 (March 1968). At the very minimum those with incomes below the poverty line should be exempt from all co-insurance and deductible requirements.

A. Section 209 Restrictions on Eligibility

Though obscurely drafted, § 209 contains several critical provisions which will limit Medicaid eligibility more severely than current law. States participating in Title XIX will continue to be required to provide medical assistance; as defined in § 1902 (a) (13) and § 1905(a) of the Act, to families with AFDC attributes,⁹ to the adult recipients under a new Title XX, and to children receiving foster care. Yet under this section states will not be required to provide medical assistance to the additional "intact" families who will be eligible for FAP and OFF; i.e. the working poor. Furthermore, states will not be required to continue coverage of all AFDC families presently eligible; only those AFDC families who are receiving assistance under Title XXI must be included in a minimum Title XIX program.¹⁰ Also, states will not be required to raise their income eligibility levels for Medicaid to correspond with Title XX or XXI income eligibility standards but may maintain their Medicaid eligibility standards at the levels existing on January 1, 1971, which may be well below Title XX or XXI standards. (§ 1902(e) of the Act as added by § 209(d) of H.R. 1) This would deny medical assistance to some individuals receiving assistance under Title XX or AFDC related families receiving assistance under Title XXI.¹¹

In addition, a substantial number of families now receiving cash assistance and eligible for Medicaid in states with minimum Title XIX programs¹² will not automatically be eligible for Medicaid under § 209(c) of the Act even if they are eligible for FAP. This results from the fact that full application of the earned income disregards available to families in determining FAP and OFF eligibility is specifically prohibited in determining Medicaid eligibility. Families previously eligible for AFDC and now eligible for FAP and OFF will be limited to an earned income disregard of only \$720, an amount equal to just the flat dollar portion of the disregard available to determine cash benefits.¹³ Under current law, pursuant to § 1902(a) (17) of the Act, the same earned income disregards are applicable to determine eligibility for Medicaid as are applied to determine continuing and initial eligibility for money payments in the respective categories. Thus currently there is eligibility for Medicaid once a person is deemed eligible

⁹ Families where one parent is disabled, dead or absent from the home as well as families formerly deemed eligible for AFDC-UF (where the male head of the household is unemployed) in states which had AFDC-UF programs.

¹⁰ Some families presently eligible for AFDC in states in which the assistance standard exceeds the proposed FAP level will not be eligible for assistance under Title XXI unless the state elects to provide supplementary assistance. If the state does not so elect, it would not be required to aid such families under the new Title XIX program. It seems clear, however, that if the state does so elect, any AFDC type family receiving supplementary payments must be included in the minimal Title XIX program, although question could be raised by use of the term "receiving assistance to needy families with children" in § 1902(a) (10) (A).

¹¹ An AFDC related family receiving assistance under Title XXI need not be covered unless the total family income less \$720 a year plus medical expenses is below the state's January 1971 standard. Accordingly, in states where FAP adds families to the cash rolls, the states need not make such families automatically eligible for Medicaid and they may be required to apply their increased assistance to meet their medical care expenses.

¹² Under current law, pursuant to § 1902(a) (10) of Title XIX, a state opting to have a Medicaid program is required to provide medical assistance to all categorical assistance recipients.

¹³ This disregard is \$720 plus one-third of the remainder of earned income. The \$720 disregard represents an allowance for work expenses established on the assumption that actual work expenses, carfare, lunches, etc. average about \$60 a month. The bill is unclear on what disregards will be allowed for Title XX recipients. Section 1903(f) (3) states that only the flat dollar portion of the disregards allowed for purposes of determining eligibility for cash assistance under Title XX, as set out in § 2012(b) (3), will be used for determining eligibility for medical assistance. This would mean a disregard of \$1,020 for the blind and disabled and \$720 for the elderly. However, § 1903(f) (1) (A) seems to allow states to use the full disregards provided for in § 2012(b) (3) with respect to adults eligible for Title XX payments, since this subsection, unlike 1903(f) (1) (B), prohibits federal matching only as to individuals *not receiving* assistance, whose net income, after application of the more restrictive medical assistance disregards, established under 1903(f) (3), is in excess of maintenance levels. See § 1903(f) (1) (B). Thus the more restrictive disregard in the adult category appears to apply only with regard to the medically needy; whereas for the AFDC linked FAP and OFF families the more limited disregard applies to both the categorically and medically needy. Thus some medically needy Title XX and XXI recipients, formerly eligible for Medicaid because of the earned income disregards, will no longer be eligible without spending down below the Medicaid assistance standard.

for, or is receiving, a money payment. Under H.R. 1, such automatic, concurrent, parallel eligibility will be eliminated for families receiving cash payments.

For example, a family which earns \$300 per month in a state which provides only the required minimal Title XIX program and does not provide cash supplementation for the minimum FAP standard of need of \$200 per month for a family of four would not be eligible for Medicaid despite its eligibility for FAP. Under present law \$180 of the family's \$300 per month earned income would be disregarded for the purpose of determining continuing eligibility for a money payment.¹⁴ Assuming a state standard of \$200, the family would be eligible to receive public assistance supplementation of \$80 and would be eligible for Medicaid. Under H.R. 1 such a family would be eligible for Title XXI payments of \$40 a month, but would not be eligible for Medicaid since the family would be entitled to a disregard of only \$60 and would be treated for Medicaid eligibility purposes as having income above the eligibility levels, i.e. \$280 per month, \$240 of countable income and \$40 benefits.

Such families who will be eligible for cash assistance but no longer automatically eligible for Medicaid will be forced to "spend down" in order to qualify for Medicaid, i.e. they will have to meet their own medical expenses up to the amount by which their income exceeds the medical assistance standard and will only receive medical assistance to meet medical costs above that amount. In the example above, the family would not qualify for medical assistance in any month unless their medical expenses for such month exceeded \$80, and then they would be relieved only of the costs in excess of \$80. Thus, a family with actual gross income of only \$340 would have to apply \$80 of that income to medical needs even though \$340 a month is the amount which the family has been determined to need under FAP to meet its basic maintenance costs other than medical care. In addition, if a state sets its medical assistance level at the level in effect as of January 1, 1971 (p. 5, *supra*) the spend down might be more.

Imposition of a spend down requirement on families in need of cash assistance is one of the most deviously regressive features of the amendments. Thus the purported purpose of this spend down provision is to eliminate what was felt to be a "notch" or work disincentive under the current program.¹⁵ However, Congress has not only failed to cure that problem, but has created an even greater work disincentive penalizing admittedly needy individuals who are able to supplement their assistance with earned income.

The Medicaid notch refers to the current problem resulting from the fact that at a certain point one additional dollar of earned income means the loss of the last dollar of cash benefits and the concomitant loss of Medicaid. Although the income disregard provisions contained in the 1967 amendments were supposed to assure that loss of cash benefits from earned income would be gradual and that there would be no work disincentive, no similar phase-out was provided for Medicaid. Congress failed to recognize the work disincentive in requiring a family to meet its own medical costs at a point where the family income was just sufficient to disqualify it from public assistance. At one income level, the family or individual is eligible for free medical care; with the next dollar earned which terminates cash assistance, they are suddenly responsible for all of their medical expenses.

This problem is especially severe in states which only provide medical assistance to the categorically needy. In such states the family can never spend down out of income in order to qualify for Medicaid. They can only become eligible if their actual income again falls below cash assistance levels so that they qualify for receipt of such assistance. The notch effect is further compounded by the inapplicability of the earned income disregards in determining initial eligibility so that only repauperization could reestablish eligibility for cash assistance.

As noted above, rather than eliminating work disincentive, § 209 adds to it. By eliminating the full applicability of the earned income disregards to families receiving assistance under Title XXI and substituting a spending down requirement for Medicaid eligibility, the work incentive carefully built into the cash assistance program for families is removed. Currently, for each \$3,000 earned, cash benefits are reduced by \$2.00. Families are allowed to keep the remaining dollar as a work incentive. But the requirement of a spend down means that the

¹⁴ Disregarding \$30 and 1/3 of the remainder plus work expenses. For these purposes the family is assumed to have work expenses of \$60 per month.

¹⁵ H.R. Rep. No. 231, 92d Cong., first sess., p. 74.

dollar retained as a work incentive must be spent on medical care (if medical expenses are incurred) in order to become eligible for Medicaid. Families which have medical costs may find they have worked and earned income with no gain. Furthermore, the amendments do not cure the problem of barring non-cash recipients from medical assistance regardless of their medical expenses in states which provide only a minimal program.

Clearly a spend down provision should be applied even in the minimal program so that people with income above assistance levels can receive Medicaid without going on cash assistance, i.e. at the point where the income remaining after medical expenses is equal to cash assistance eligibility levels. However, to propose that cash recipients spend part of the income left to them as a work incentive (or indeed, if medical assistance levels are low enough, part of their cash grants)¹⁶ on medical care, cynically disregards their need for the essentials on which they have spent their money in the past, and unquestionably frustrates the congressional purpose which led to the original inclusion of the income disregard provision as a work incentive. It should be clear that the intent of § 209 is not to allow a more reasonable administration of the Medicaid program that would eliminate work disincentives, but is purely to save costs by lowering Medicaid eligibility levels, cutting families with only subsistence income from the Medicaid rolls, and forcing them to spend down in order to receive medical assistance.

In addition to the minimum Title XIX program, and consistent with present law, under H.R. 1, states will be permitted to establish a program for individuals whose income and resources exceed Title XX and XXI levels (a Group II program). Essentially this program will be similar in structure to the program which many states now have elected to maintain for the categorically related medically indigent. Yet it contains several regressive features.

Currently the maintenance level for this group must be established at the most liberal money payment standard since July 1, 1966 or at the level of 133% of the ADC payment level, whichever is less. 45 C.F.R. § 248.21(a)(3)(1)(b). H.R. 1, however, would permit the maintenance level to be established at a minimum, at just above (101% of) the highest amount that would be payable under Title XXI to an eligible family of the same size without any income or resources plus the amount of the supplementary payment, if any, made by such state. This allows states to have a maintenance level lower than is permitted under current law. With lower maintenance levels for the Group II beneficiaries, many individuals with income and resources greater than Title XX and XXI recipients, eligible under current law for medical assistance without spending down will become eligible for Medicaid only at such time as they incur medical expenses which bring them below the maintenance levels established by the state. It should be noted, in connection with the inapplicability of the earned income disregards for the purpose of determining Title XIX eligibility, and the consequent lack identity between individuals eligible for Title XXI money payments and those eligible for Medicaid, that many families formerly eligible for Medicaid and receiving FAP or OFF payments would not automatically be eligible for Medicaid as Group II beneficiaries since their income would still exceed the maintenance levels established by the state for its Group II program.

Furthermore, the state may again determine eligibility under the provisions of its January 1971 plan. This affects not only financial eligibility but also the classes of people to be covered. Notwithstanding the language of § 1902(a)(10)(B) which would appear to mandate coverage of children in working poor families receiving FAP and of all families with income below the eligibility standard, the state is not required to expand its 1971 program.¹⁷ Pursuant to § 1902(e) it may deny aid to children under 21 in a non-AFDC related family if it did not

¹⁶ In some States, such as South Carolina and Texas, the January 1, 1971 assistance standard would be below the FAP minimum payment level of \$2,400. Requiring individuals to spend down to the 1971 levels in such instances would result in the undesirable situation of the State medical assistance agency taking away what the FAP Federal agency gives.

¹⁷ The view of § 209 which makes intact families eligible for Medicaid under Group II programs is based on a literal reading of the amended § 1902(a)(10)(B)(i). The problems raised by this provision that are discussed in this comment and the fact that the section as written would make medical assistance available to intact families not receiving cash assistance while denying medical assistance to intact families receiving cash assistance, has led some to question whether there is not a mistake in the draftsmanship and whether Group II coverage was not intended for AFDC type families only.

previously cover such children.¹⁸ States would have the option to include all Title XXI children if they so choose, with federal matching, so long as the income of such families, after deduction of medical expenses, falls within the maintenance level established by the state. Apparently, however, states can pick and choose with respect to application of § 1902(e) so that a state could opt to add coverage of children under 21 without adding parents in an intact family. It is extremely unlikely that any state would cover such parents since federal matching is not available for the costs of such assistance (§ 544(18)(B)).

There is one limit on the state's exclusion from Group II of children under 21 in a family. It must include such children if the total family income less \$720+medical expenses is under its January 1, 1971 medical assistance standard and such children were covered under the state's plan in effect on January 1, 1971. Of course, should a state choose not to have a Group II program for the medically needy (and under H.R. L states might even be permitted to drop already existing medically needy programs, § 230 and 231) families and individuals with incomes above the state medical assistance standard would be unable to spend down and receive any medical assistance.

Obviously there are problems with § 209 which must be corrected in order to assure that adequate health care is available to the poor and the needy, for the effect of this section would be to establish a federally enforced Medicaid cutback. A question of what should be done arises.

The most significant problem presented by § 209 is that there would no longer be automatic Medicaid eligibility for families receiving cash assistance. Not only does the section not extend coverage to families with AFDC attributes which will be newly eligible for assistance under Title XXI (let alone the "intact" families which will be eligible), indeed, it cuts back eligibility for a large number of families currently receiving Medicaid concurrently with their receipt of cash benefits. As described above, these families are required to spend down in order to receive assistance, a situation which somehow seems inconsistent with the reasons cash assistance is being provided them. In order to correct this situation it would be optimal were H.R. 1 amended to provide that all families receiving cash assistance under Title XXI, including the "intact" families, be automatically and concurrently eligible for Medicaid. A less desirable alternative would be to amend the bill to make all families who are currently receiving assistance and who would continue to receive cash assistance under Title XXI automatically eligible for Medicaid. Either of these changes would require a change in § 209 providing for the allowance of the same income disregards for purposes of determining Medicaid eligibility as would be used to determine eligibility for cash assistance. This would be consistent with current law.

No matter which alternative is selected for the above purpose, § 209 should be amended to allow Title XXI families and title XX individuals with incomes above the medical assistance standard and the cash assistance level to spend down to the medical assistance standard in order to gain Medicaid coverage even if their state does not choose to have a program for the medically needy.

States should not be allowed to vary the extent of their medically needy programs. Any groups eligible for cash assistance should be eligible for Medicaid without regard to the coverage and eligibility standards of the state's 1971 program. It is foolishness if not cruelty to recognize individuals or families as being in need of cash assistance and then deny them medical assistance because their need was previously ignored. Even efficient administration argues against the proliferation of standards and tests introduced by § 1902(e). The eligibility determination in Title XIX is already exceedingly complex because of the need for constant reevaluation to reflect changes in income and incurred expenses. If several different tests are to be applied, the program would become virtually unmanageable precluding any certainty as to eligibility in an individual case.

Furthermore, § 1902(e) is so poorly drafted that there are bound to be substantial differences in application due to divergent interpretations and the innumerable questions which it raises. For example, it ties eligibility to an "approved" January 1971 Medicaid plan. What if it is determined now or in the

¹⁸ The bill as it now reads does not clearly require states which include all children who are needy, regardless of categorical linkage, in their Title XIX program, to continue providing medical assistance to such children in the mandatory minimum program. Thus states which have exercised the so-called Ribicoff option under Section 1905(a) of Title XIX are not specifically required to include such children in their minimum Medicaid program under the language of § 209(a).

future that individuals would have been denied benefits under such plan as the basis of an illegal qualification? Does the fact that the plan was nonetheless "approved" perpetuate such illegality?¹⁹ Also is the spenddown in § 1902(e) an exception to an exception? The treatment of § 1902(e) in the discussion above has been based on the language of the statute which excepts individuals or families with certain income from being denied eligibility because they could not have qualified under the 1971 plan. However, the committee report described such exception as if it were only intended to prevent a state which had a 1971 standard in excess of its new standards from determining eligibility by use of the income disregards mandated in the 1971 plan, i.e. \$30+ $\frac{1}{3}$, as opposed to the \$60 allowed in the new Title XIX program.

Section 1902(e) may well be unparalleled in legislative non-draftsmanship. In any case, whether by intent or inattention it could well wipe out any benefit from an increase in cash assistance in low payment states by allowing the states to require the recipients to apply such income to meet their own medical care. In fact, Sections 209(c) and 209(d) are critical to an evaluation of the total benefit to be conferred under Titles XX and XXI. They represent a taking with one hand from what Congress is purporting to give with the other.

Finally, states should not be allowed to change the relationship of the medically needy program to the cash assistance level. Contrary to current practice, under H.R. 1 a state would be allowed to have its medical assistance standard for the medically needy as low as 101 percent of the cash payment level. This standard should be required to be maintained at 133 percent of that level or at the level of the most liberal payment level used in any category since July 1966, whichever is higher.

B. Section 203—Repeal of Requirement of Expanded Programs

Section 230 of the bill would repeal § 1903(e) of the Medicaid Law so as to remove the requirement that states make efforts to provide comprehensive medical services to all the needy by July 1, 1977. Section 1903(e) expresses the very heart of congressional intent in enacting Medicaid; a broad and comprehensive scope of needed services is to be made available to all who need them.²⁰ For Congress to repeal this most basic section without carefully studying the implications of its action on the entire Title XIX program, would be rash and unwise. Repeal of § 1903(e) would undercut and emasculate the future of Medicaid, since states would no longer be required to maintain or improve their programs and could reduce them to nonexistence. It is proposed that § 230 be deleted.

C. Section 231—Reduction in Current Programs

Section 231 of the bill limits the application of § 1902(d) which requires prior approval of the Secretary of any reductions or terminations of services or programs in the state medical assistance plan, by requiring such prior approval only for modifications in the scope of services required under § 1902(a) (13) (the five basic services).

Section 1902(d) was enacted to preserve the original Title XIX goal of obtaining truly adequate, i.e. comprehensive, medical care. Permitting states indiscriminately to reduce services other than the basic five, with no requirement of prior HEW approval or utilization control, ignores Congress' concern for balancing a state's fiscal interest in cutting Medicaid expenditures and the recipient's interest in protection against state's irresponsible management of medical delivery.²¹ The optional services are vitally important to provision of efficient and high quality medical care. For example, the need for the inclusion of drugs as a medical care benefit has been well documented.²² To exclude drugs would severely constrain and limit those procedures by which the physician can assure good personal medical care. If a physician were limited to using non-drug

¹⁹ This is not a speculative issue. At the present time there is pending in the United States Supreme Court a challenge to a method of computing AFDC payments which has been approved by HEW which places severe limits on Medicaid eligibility. *Jefferson v. Hackney*, No. 70-5064, Term 1971, probable jurisdiction noted 40 U.S.L.W. 3161 (Oct. 12, 1971). This same question is presented in at least 23 other states.

²⁰ See remarks of Congressman Mills, author of the bill, 111 Cong. Rec. 7209 (1965) and Report of House Ways and Means Comm. No. 213, 89th Cong., 1st Sess. (1965) at 20, 74. ²¹ See remarks of Senators Long, Harris and Ribicoff at 115 Cong. Rec. 17702-17704 (June 30, 1969).

²² R. Froh, "New Systems for Health Care" 510 J.A.P.H.A. No. 9 (September 1970).

diagnostic and therapeutic treatment procedures we would be forced to practice nineteenth century medicine. Furthermore, the total costs of providing medical care without drugs would be greater than if drugs were available. For example, officials of the National Institute of Mental Health have observed that the sharp decrease in hospitalized mental patients, resulting in need for fewer mental health beds, is due primarily to improvements in the use of drugs both in combat mental illnesses and to calm disturbed patients, allowing them to receive other therapy.²³ Estimates of the savings of mental hospital construction due to the introduction of tranquilizers have been projected at \$5 billion.²⁴ Similar reductions in total health expenditures have been recognized through the use of antitubercular drugs on an outpatient basis.

In addition, the use of pharmacologic agents in the treatment of a variety of acute and chronic diseases (i.e., rheumatic heart disease; types of pneumonia(s); otitis media; brucellosis) has allowed patients to be treated on an ambulatory basis and not in an expensive hospital. Such treatment modalities decrease the need for expensive facilities while at the same time allowing the patient to carry on fairly routine activities.

To prevent any cutbacks in the Medicaid program which would have a drastic effect on those in the country who need health care most of all, it is recommended that § 231 of H.R. 1 be repealed.

III. THE USE OF HMO'S UNDER MEDICARE AND MEDICAID, §§ 207 AND 226

H.R. 1 goes a long way to encourage the use of group prepaid health plans—or at least the Nixon hybrid called health maintenance organizations (HMO's)—under Medicare and Medicaid. Section 207 of the bill does this by providing a financial incentive in the form of an increase in federal matching funds to states that choose to contract with HMO's or community health centers to provide health care to their Medicaid recipients. Under this section a state's federal matching percentage would be increased by 25%, up to a maximum of 95%, as long as the state does not allow contracting organizations to charge more than the fee-for-service systems under its medical assistance plan. Section 226 of the bill provides for making payments to HMO's for Medicare recipients.

In general, encouragement of the use of prepaid health plans may be a positive goal. Data from on-going prepaid comprehensive health care organizations strongly suggest that the cost of medical care is less and can be more effectively contained than the cost of individual fee-for-service medical services. Moreover, based on the experience of some currently operating programs, the quality of medical services as measured by infant mortality and longevity is higher than that dispensed by individual fee-for-service practices. Finally, such plans can provide complete medical care, obviating the necessity for an individual to travel from physician to physician for his various health needs.

Yet there are problems with HMO's which must be cleared up before such plans are allowed to enroll Medicaid and Medicare recipients in large numbers. Perhaps the most serious of these is their potential for "built in" underutilization.²⁵ In the fee-for-service system doctors have an economic incentive to see a patient as often as possible and provide as many services as possible because the more services he provides, the more he will be paid. This system has resulted in the overutilization and unnecessary use of health facilities. However, in an HMO where payment is made on a flat rate per capita basis, the financial incentive is just the opposite. In order to make their operations financially successful HMO's particularly those that are proprietary, may be encouraged to provide as little care as possible.

A second and related HMO problem stems from the fact that since HMO's do provide comprehensive care and are in fact a person's sole source of health care, individuals using an HMO, and communities served by HMO's will be highly dependent on their services, making it crucial that they are publicly accountable. Yet given that an HMO's economic incentive potentially presses towards underprovision of services and care, there is a great possibility that the interests of the HMO's administration and those of the enrolled population in the community will not mesh on such issues as whether there are adequate facilities, when the outpatient clinic should be open, or whether there are enough physicians on staff.

²³ Washington Post, Oct. 4, 1968.

²⁴ Prescription Drug Industry Fact Book, 1968.

²⁵ Somers & Somers, *Medicare and the Hospitals*, p. 194.

There is evidence of this problem in the Kaiser operation in California. For example, in 1970, certain Kaiser hospitals in Southern California and some in the San Francisco-Sacramento area at times reported occupancy rates of 100-110 percent.²⁶ Waiting times for outpatient appointments have commonly run from three to six weeks, and in one large group, as high as 55 days. Although Kaiser members can take advantage of non-appointment clinics where waiting time is less than one hour, to do so they have to be willing to see whatever doctor is available rather than their regular family physician. A recent study showed that 44% of the Kaiser plan members in Southern California had sought medical services outside the plan for reasons ranging from convenience, to medical emergency, to dissatisfaction with Kaiser facilities. *Id.* at 83. It should be noted that Kaiser is not the only pre-paid group practice where consumers use services outside the plan. Outside physicians are used for 37% of the surgical operations at the Health Insurance Plan of Greater New York and 23% of physicians' and dentists' services at the Labor Health Institute of St. Louis.²⁷

Possibly another problem of accessibility or availability under the proposed HMO scheme is that it allows for the possibility that an HMO will be only a loosely connected group of individual physicians or groups of physicians. (§ 226 (a)—proposed § 1876(b) (203)). There is no assurance that these physicians will be located in an area convenient to the enrolled population of the HMO. Also under such an arrangement, if a physician works part-time for an HMO and has a fee-for-service practice part-time, it is to his financial advantage to neglect his HMO patients whose care has been prepaid so that he can increase the number of fees he earns. For just these reasons Dr. Robert Gumbiner of the Family Health Program of Long Beach, a multi-specialty group practice in California has recommended that plan physicians should be on the staff full-time.²⁸ At the Family Health Program, this is a requirement.

To avoid these problems, H.R. 1 provides only that an HMO must demonstrate to the Secretary of HEW that it will be "capable" of providing comprehensive health services "efficiently, effectively, and economically," and that the HMO "assures that the health services required by its members are received promptly." There is no provision which assigns to anyone the task of insuring that the HMO is actually performing its functions and that its services are readily available and of high quality.

To cope with this situation it is imperative that H.R. 1 be amended to provide for certain consumer safeguards.

First, HMO's must be capable of providing comprehensive care. While § 226 would require that HMO's receiving Medicare funds must be capable of providing directly or indirectly all benefits under Parts A and B of Medicare, there is no similar provision which insures that HMO's contracted with to provide services to Medicaid beneficiaries will be prepared to provide all basic Medicaid services as laid out in § 1902(a) (13). Section 207 should be amended to make it clear that such HMO's must be able to provide directly or make arrangements to provide at least these services which would include: (1) inpatient hospital services; (2) outpatient hospital services; (3) laboratory and x-ray services; (4) skilled nursing services for individuals 21 or over, and diagnostic screening for those under 21; (5) primary and specialized physician services, and (6) outpatient drugs where required by the state medical assistance plan. By arranging these basic services on a prepaid basis, the health care provider will have a range of provider options available to him and thus, can utilize a lower-cost option of medical care delivery while at the same time insuring that the care rendered is of high quality and medically appropriate. This requirement would provide an incentive for providers to treat early those diseases and illnesses which, if left unattended, would develop at a later date into more expensive-to-treat conditions.

Secondly, there should be minimum requirements for physician staffing of HMO's. Generally an HMO's staff should be composed of physicians representing

²⁶ "Occupancy in excess of 100 percent means putting beds in corridors. It also means scheduling patients for major surgery without an available empty bed. The patient is prepared for surgery as an ambulatory patient, goes into the recovery room after surgery, and waits there for hospital bed assignment. If a bed does not open up by the time he needs to be moved, the administrative and nursing staff review the patient list to see who can be sent home, to another hospital, or to an extended care facility." G. Williams, *Kaiser Health Plan*, Modern Hospital, February 1969, p. 9.

²⁷ Donabedian, A. "An Evaluation of Pre-Paid Group Practice" *Inquiry*, vol. 6, No. 3, September 1969, p. 9.

²⁸ Testimony before the California State Assembly Health Committee, Mar. 1, 1971.

on a *full-time* basis four medical specialities: pediatrics, internal medicine, general surgery, and obstetrics-gynecology. This provision should be subject to waiver by the Secretary if such a requirement is not feasible, as may be the case in a rural community; or if, because of the make-up of a community, one of the specialists, such as a pediatrician, would not be necessary. Additionally, if the HMO has a large staff, at least one-half of the full-time physicians should be primary care physicians (general practitioner, internist or pediatrician) since the majority of medical care needs can be performed by such a physician.

Third, there should be a minimum physician/enrollee ratios. HMO's should not enroll more than 1600 persons per primary care physician and 1200 persons per each full-time equivalent physician. These standards are based on actual physician/enrollee ratios of existing HMO-like programs.²⁹ Here again, although the Secretary must utilize such ratios in order to insure that an HMO will not enroll more patients than it can handle, the Secretary should be permitted to adjust the ratio if he feels it is necessary. It is crucial with regard to this ratio that no enrollment be permitted on the basis of part-time primary care physicians. This is so because part-time personnel are unable to provide desirable continuity of care and because, as noted above, a part-time physician who has an outside fee-for service practice may not be sufficiently devoted to prepaid practice.

Fourth, only Board eligible or certified surgeons should be permitted to perform surgery except in a medical emergency. Currently too much unnecessary surgery, particularly elective surgery, takes place. Data from across the country has documented this fact,³⁰ and reports indicate that many of the unnecessary procedures are performed by non-specialized physicians who do not have the proper training or experience in surgery.³¹ The proposed restriction is necessary to abate this costly and hazardous overutilization of surgery.

Fifth, HMO's should be required to refer patients to outside specialists whenever medically appropriate. Such a requirement would help to control the tendency of some HMO's to perform medical services, even when it does not have adequate and appropriate medical staff, rather than send a member to an outside specialist whose fee will have to be paid out of the HMO's pre-paid fees.

Sixth, HMO's should be required by the end of a two or three year period to enroll at least 20,000 individuals in the program. Past experience of HMO-like health plans shows that HMO's must have responsibility for a minimum population of 20,000 to stabilize their operation.³² When serving fewer than 20,000 people on a prepaid basis, HMO's are likely to not have sufficient capital to cover expenses if catastrophic illness occurs, and may go bankrupt. To guard against such a contingency, the Secretary might require a re-insurance coverage for those HMO's which have not achieved the minimum population size.

Seventh, not more than 50 percent of the enrollee population should be eligible for Title XVIII or XIX medical assistance. Otherwise there might be HMO's which just provide care for the poor or just provide care for the aged—a situation which does not lead to good quality of care, and as experience has shown us, is one to be avoided.

Finally, consumers and individuals representing consumer groups must be provided an opportunity to participate in decision-making in their health care programs. Although there is question whether consumers can effectively participate in certain narrow areas, such as the determination of whether a particular medical procedure is appropriate, there is no doubt that consumers and local community groups are the best judges of when their health providers are doing an effective and efficient job. They can make productive contributions in such areas as determining when services should be available and when to place ambulatory care programs; and they can make it known when services being pro-

²⁹ J. E. Hastings, "Labour's Plan for a Medical Care Program for Toronto," September 1962; D. DuBois "Recommendations for Development of a University Community Health Service and Prepayment Plan, undated memorandum; M. D. McLaughlin, "Neighborhood Family Care Center 55 Program," Health Services Administration, New York City, November 1967. All three of these documents based physician staffing profiles on the Health Insurance Plan of Greater New York (HIP) and Kaiser Foundation.

³⁰ G. S. Perrott and J. C. Chase "The Federal Employees Health Benefits Program: Sixth Term Coverage and Utilization," Group Health and Welfare News, Special Supplement (October 1968).

³¹ "A Medical Audit Report: Comparison of the Findings in a 200-bed Suburban Hospital with Those in University Teaching Hospitals," School of Public Health, U.C.L.A., 1965; R. Trussell and M. Morehead, *et al.*, by a Sample of Teamster Families in the New York Area, New York, Columbia University School of Public Health and Administrative Medicine, 1962, 83 pp. (P. Lembeke).

³² See fn. 23 *Supra*.

vided are inadequate both as to the scope of covered services and the quality and effectiveness of services offered. Without consumer input what has resulted in the past has been a reflection of convenience to the medical profession and the needs of health institutions rather than the needs and conveniences of health consumers. To understand this one need only look to the operation of Blue Cross plans throughout the country which have been largely controlled by providers and have done little in the consumers' behalf. For example, traditionally Blue Cross has offered coverage only for inpatient hospital care.³³ Even in cases where a procedure might be done equally as well on an outpatient basis, under such a plan subscribers are 'forced' by the confines of their Blue Cross policy to use more expensive inpatient hospital care. The result: unnecessary overutilization of hospitals and higher Blue Cross premiums. Similarly, Blue Cross plans have failed to cut drug costs by insisting that hospitals prescribe generic drugs—whose use would cut drug costs by an estimated 10%.³⁴ Although these particular problems of overutilization and excessive costs are those which an HMO's financial incentives are meant to take care of, as discussed above, there is a great potential for similar consumer-provider conflicts to develop in the HMO scheme. Just as it was not realistic to believe that providers and provider dominated institutions would look out for consumer interests in the past, there is no reason they will do so now. For example, cost problems *could* be solved in HMO's through effective programs that would cut down unnecessary utilization, but they also *could* be solved by the provision of inadequate health care. For this reason, it is imperative that all HMO's have a governing board with a substantial percentage of subscriber/enrollee representatives as well as representatives chosen by the subscriber/enrollees. Additionally, each HMO must establish a procedure whereby consumer grievances can be effectively aired and acted upon.

There are obvious problems with these two sections which should be corrected by amending H.R. 1:

1. Although § 207 explicitly allows Medicaid payments to be made to community health centers which would presumably include—though it is not absolutely clear—OEO neighborhood health centers, as well as HMO's, § 226 speaks only in terms of HMO's. Though OEO community health centers would probably qualify as HMO's under the language of § 226, the statute should be amended to make this explicit.

2. Section 226 provides that the Secretary can terminate an agreement with an HMO after notice and a hearing are given the provider, but the bill does not require notice or a hearing to the enrollee. This should be required.

IV. DISINCENTIVES FOR EXTENDED INSTITUTIONALIZATION §§ 207 AND 224

In addition to providing incentives for states to use HMO's, § 207 also provides disincentives to institutionalize patients for long periods by decreasing federal matching to facilities other than HMO's: a) decreasing by $\frac{1}{3}$ federal matching for inpatient hospital services beyond 60 days, whether or not consecutive; b) decreasing by $\frac{1}{3}$ federal matching for skilled nursing home services beyond 60 days whether or not consecutive, unless the state has an effective utilization control mechanism over skilled nursing home services, a physician periodically reviews the necessity of the services, the state has a utilization review plan as required by § 1902a(30) and the state has a medical review plan as required by § 1902a(26); c) decreasing by $\frac{1}{3}$ the federal matching for inpatient mental hospital services beyond 90 days, whether or not consecutive, (plus 30 additional days when the Secretary has been shown that the individual is receiving active treatment in the hospital and the prognosis is one of continued therapeutic improvement). No payment is to be made for inpatient mental hospital services after 365 days.

It seems arbitrary and unreasonable to decrease federal matching for inpatient hospital services and inpatient mental hospital services after sixty days and ninety (plus thirty) days respectively, regardless of whether or not continued care is medically necessary, however it may be determined.

In order to continue providing hospital and mental hospital care where such care is medically necessary, states would have to suffer serious financial strain.

³³ Ehreneich, *The American Health Empire*, p. 156.

³⁴ Denenberg, *Guidelines for Inclusion in Blue Cross Contract with Delaware Valley Hospital Assn.*, 1971.

The best method to control utilization is by requiring certification of doctors and a hospital's utilization review committee that continued care is necessary. This method is required for Medicaid claims under H.R. 1; it is the basis of extensions of full matching for nursing home care; and it should be relied upon in this instance. At the very least, the statute should be amended to allow full federal matching for all types of care and eliminating all upper limits on inpatient mental hospital care whenever a physician certifies the medical necessity of care and such state has in effect an approved utilization review program.

§ 224 of the bill puts a limit on charges for skilled nursing home and ICF services at 105% of the average per diem cost of the services for the 4th calendar quarter preceeding the quarter in question, but the Secretary has authority to increase the percentage. This provision does not burden the consumer unless nursing homes are permitted to charge coinsurance or refuse to serve Medicaid patients.

V. CHARGES TO MEDICARE BENEFICIARIES, § 223

Section 223(a) of H.R. 1 provides that hospitals will only be reimbursed under Medicare for "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." This provision might well be applauded as a welcome departure from past Medicare policy of reimbursing hospitals for whatever their costs were, were it not for § 223(e) which permits hospitals to charge Medicare recipients for all costs not reimbursed by the government. Presently providers of health services are not allowed to charge Medicare recipients for care they receive. The one exception to this is "where a provider has furnished *at an individual's request*, items or services in excess of or more expensive than those for which Medicare allowed payment." (emphasis added) Yet subsection (3) of § 223 would seriously change this. It would allow providers to charge individuals not only where they have requested special care, but additionally where services are "customarily" provided "which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services . . . (and) *which have not been requested by such individual.*"

This is merely another in a line of changes in Medicare policy designed to move the costs of the program from the government to the consumers. Yet in this instance, despite initial savings to the program, the change goes against good long-range fiscal policy. For while the government, with its vast purchasing power, has the opportunity to force hospitals and health providers to economize by refusing to reimburse more than costs which are determined to stem from the "efficient" delivery of health care, it gives up this opportunity by allowing hospitals to pass on the costs of inefficiency to health consumers. In the long run what this means is ever inflating hospital costs at a time when they have already soared beyond all estimates.

In order to correct this and enact a provision that really will contain hospital costs, § 223 should be amended to continue to allow the government to trim their reimbursement to hospitals, but subsection (e) should be deleted so as not to allow hospitals to pass on their costs of inefficiency to the consumer. The only costs which should be passed on the Medicare recipients are those for "extra services" provided, as in the past, at the request of the patient, and certainly not for necessary services which are more expensive than they would be were the hospital running as it should.

VI. APPEALS FOR MEDICARE BENEFICIARIES § 262

Under current law, beneficiaries are entitled to a hearing on any and all Part B claims. This includes claims for payment of physician's bills, x-ray tests, prostheses, etc. This hearing is before the fiscal intermediary and the decision is not reviewed by SSA. Furthermore, it is that agency's position that such decisions are not subject to judicial review.

Section 262 would limit hearing rights under Part B to cases involving claims of at least \$100. This is the same limit currently applicable to hearing rights under Part A. Both limits are unreasonable for the needy aged for whom a difference of \$10 or \$20 could represent a substantial part of a weekly fixed budget. And certainly a bill of \$95.00 to an individual trying to live on a \$100 a month Social Security budget is far from petty. Its effect is particularly egregious in Part B where by definition many if not most claims will be small amounts, e.g. an aged individual might have within a six-month period several claims for physician's services for different periods of illness, no one of which amounted to \$100.

Is such an individual to be deprived of any recourse where he disputes the decision of the carrier?

The regressive effect of this amendment is exemplified by the fact that no provision is made for judicial review of such decisions. Since the purported justification for not so providing originally was the probability of a multiplicity of small claims, it is irresponsible to place a monetary limit on hearing rights without also providing for judicial review.

Section 262 should be amended to waive the \$100 limit. In addition § 262 should be amended to amend Section 1842(b)(3)(c) of the Social Security Act to provide that the hearing be held not by the carrier but, as for Part A claims, by the Secretary of HEW. See § 1869(b) of the Social Security Act. In fact, due process may well demand no less than such changes.

Consistent with this amendment and for the same reasons, it is recommended that the longstanding limits on appeals for Part A claims be similarly abolished.

VII. COMPREHENSIVE HEALTH PLANNING § 221

Section 221 of H.R. 1 allows the Secretary to refuse to reimburse health facilities for capital expenditures (e.g. depreciation, interest, return on equity) when the expenditures are for projects which are out of conformity with the area comprehensive health plan as determined by a designated state planning agency. The purpose of this provision is to encourage the development of health facilities in a way that will best promote quality of health care while keeping down costs. The Secretary may waive this requirement, however, if the provider has demonstrated that it is able to provide comprehensive health care services "efficiently, effectively, and economically" or that such failure to reimburse would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of the Medicare and Medicaid programs. The major problem with the section is that there is no clear opportunity for community input into the Secretary's determination either to withhold reimbursement for capital expenditures or to reimburse despite a contrary recommendation from the state planning agency. There will obviously be times when local communities will disagree with state agencies on the need for the expansion of local health facilities, and these disagreements must have a chance to be aired.

The bill does provide that "any person dissatisfied with a determination by the Secretary . . . may within six months following notification of such determination request the Secretary to reconsider such determination." This does not seem to be enough, however, to alert consumers that there has been such a vital decision made which will likely have a great effect on their community. Provision should be clearly built into the statute to publish notice of the Secretary's determination and arrange for public hearings if members of the community are dissatisfied with the Secretary's determination. In addition, the bill provides that "a determination by the Secretary under this section shall not be subject to administrative or judicial review." This should be changed.

Finally, although the bill states that the Secretary must consult an advisory board before making a decision to waive requirements and allow reimbursement, the statute provides that such a board should be chosen, "from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are state or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups." This language does not insure that the non-professional, consumer public will have any representation. It should be amended to provide that at least one-half of the board will be drawn from that group.

VIII. REMOVING UNCERTAINTY OF PAYMENT UNDER MEDICARE

In its report on H.R. 1 the Ways and Means Committee states, "Under present law, the utilization review committee required to function in each hospital and extended care facility must review all long-stay cases and at least a sample of admissions. When in the review of a long-stay case the utilization review committee determines that further stay in the institution is not medically necessary, the committee is required to notify promptly the physician, the patient, and the institution of its finding. No payment is made for any services furnished after the third day following notification." One might assume from this that before an individual's care can be terminated he must receive notice that it is no longer medically necessary. In fact, this is not the way the program has been functioning at all and a major problem is that individuals are discharged from hospitals only

to find months later that their stay is not going to be paid for by Medicare. The uncertainty this causes the elderly is obvious. For this reason Title 18 should be amended to emphasize that care may not be terminated unless an individual is given notice of a finding that care is no longer medically necessary. In addition, an individual should be given an opportunity for a hearing to contest an adverse finding.

IX. SECTION 228 ACCESS TO EXTENDED CARE FACILITIES AND POSTHOSPITAL HOME HEALTH CARE UNDER MEDICARE

Section 228 of H.R. 1 would allow smoother access to extended care facilities and posthospital home health care by creating a limited presumption in favor of an attending physician's certification that the care required by his patient is within the scope of these programs. Yet the bill does not go far enough in aiding those whose care still might be refused. It is important to remember that these refusals are not made by the Secretary, but by nursing home officials or the fiscal intermediary. To insure that everyone has proper access to extended care of posthospital home care it is proposed that the presumption created by the bill should not be able to be rebutted without notice to an individual and his physician and an opportunity for a hearing before the Secretary. In addition, in situations where the presumption does not apply, an individual should be given the opportunity for a hearing on a denial of a request for extended care of posthospital home care.

X. INCLUSION OF ICF CARE UNDER TITLE XIX, § 254

Section 254 brings intermediate care facilities under Title XIX and provides that services therein are reimbursable as medical assistance. This has the advantage of making such care accessible to the medically indigent as well as the categorically needy. The amendment also does away with the present limitation on intermediate care which confines its scope to the adult programs; children as well as aged, blind and disabled individuals could receive such services under the amendment. In addition, this provision removes the barrier to coverage of individuals in public institutions for the retarded.

However, there is one undesirable feature of the amendment which is probably attributable to error in drafting rather than design. Section 1905(a)(16) would define intermediate care facility services to exclude services in an institution for tuberculosis or mental diseases. This is similar to the 1905(a)(1) definition of inpatient hospital services. However, that definition is supplemented by 1905(a)(14) which includes inpatient hospital services for individuals over 64 in an institution for tuberculosis or mental diseases. The drafters of the ICF amendment have neglected to provide a similar corollary for 1905(a)(16). At best this is a serious oversight. At worst it is a most egregious form of discrimination. In either case, it should be corrected. The discrimination against individuals suffering from tuberculosis or mental illness already embodied in the Medicare and Medicaid programs should not be further compounded.

Provisions Which Serve the Interest of the Poor

I. RETROACTIVE ELIGIBILITY FOR MEDICAID, § 255

Section 255 requires that states provide coverage for recipients three months prior to application if the individual was eligible for assistance at the time services prior to application were furnished. This is currently permissible and is a very desirable mandate.

II. ENCOURAGING PRE-PAID PRACTICE, §§ 222 AND 240

A. Section 222, titles XVIII and XIX demonstration projects

Section 222 specifically empowers the Secretary to establish demonstration and research projects to study the feasibility of prospective payment under Title XVIII and XIX. The Secretary may waive payment requirements under Titles XVIII, XIX and V. Section 222 of the bill also amends § 402a of the 1967 Social Security Amendments to provide authorization for the Secretary to experiment to determine whether changes in methods of payment would create incentives for increasing efficiency and economy in health care and services and to determine whether payments to organizations having the capability of providing com-

prehensive care or services which are not covered, but incidental to institutional services, would result in more economical provision and effective utilization of covered services, and to determine whether the Secretary could effectively use rate schedules utilization review and medical review mechanisms. Such experiments would be valuable.

B. Section 240, title XIX freedom of choice

Section 240 of the bill waives the freedom of choice and the comparability requirements under Medicaid in order to permit individuals to enroll in comprehensive health programs which may provide more services than provided by Medicaid under the state plan. Though we don't think this amendment is required in order to authorize such enrollment, its purpose is certainly acceptable.

III. QUALITY OF CARE REVIEW, §§ 239 AND 267

A. Section 239—Quality of care review in title XVIII

Section 239 of the bill adds a new requirement that states establish a plan for professional health personnel review of the quality and appropriateness of the care and services furnished to Medicaid recipients. This provision should help assure quality of care. A similar requirement should also be made generally applicable to all Title XIX services; currently only institutional services are so reviewed in Title XIX.

B. Section 267, title XIX SNH registered nurse requirement

The requirement that a registered nurse must be in charge of a skilled nursing home under Medicaid would be amended by § 267 of the bill to permit the Secretary to waive the requirement each year until 1975 if he finds that the nursing home is located in a rural area and the supply of skilled nursing home services is insufficient to meet the residents' needs and that the nursing home makes and continues to make efforts to comply with the paragraph but is deterred by a lack of qualified nursing staff in the area. If administered carefully and only when necessary, this section could increase nursing home services in rural areas. Indiscriminate and unnecessary waivers of the supervising Registered Nurse requirement would lower the quality of skilled nursing care.

The CHAIRMAN. Daniel W. Pettengill, vice president, Aetna Life, on behalf of the Health Insurance Association of America. He does not answer.

(A statement of the Health Insurance Association of America follows. Hearing continues on p. 2736.)

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, SUBMITTED BY PAUL M. HAWKINS, WASHINGTON COUNSEL

This statement is presented on behalf of the Medicare Administration Committee of the Health Insurance Association of America. The Committee is composed of representatives of the following insurance companies: Aetna Life & Casualty, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, The Prudential Insurance Company of America, The Travelers Insurance Company, Connecticut General Life Insurance Company, CNA/insurance, Equitable Life Assurance Society of the United States, General American Life Insurance Company, Metropolitan Life Insurance Company, Occidental Life Insurance Company of California, Pan-American Life Insurance Company, and Union Mutual Life Insurance Company. Collectively, these thirteen carriers administer Part B (Supplementary Medical Insurance) benefits for approximately eight million beneficiaries including all Railroad Retirement beneficiaries, who are served by The Travelers Insurance Company. The first five companies named also serve as fiscal intermediaries for hospitals, home health agencies, and extended care facilities under Part A (Hospital Insurance Benefits).

We would like to direct your attention to four sections of H.R. 1 and respectfully urge that the suggestions made be given your serious consideration. It is our opinion that these suggestions will result in more efficient and economical administration of the Medicare Program in the areas affected.

SECTION 222—REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT: EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

The problem of adequately and fairly reimbursing institutional providers of care has been a vexing one. For sometime we have felt that the providers of care should be given an incentive for providing high quality care at reasonable prices. We strongly urge adoption of this provision which wisely authorizes experimentation and demonstration projects in all areas including performance incentives for carriers and intermediaries.

SECTION 228—ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE

While the proposed amendment provides some relief for extended care facilities and beneficiaries and their families by authorizing administrative procedures that will minimize retroactive denials of Medicare benefits, we believe it will not effectively promote greater use of the lower cost extended care facilities because it attempts to establish presumptive periods of coverage according to diagnosis and other medical information for patients admitted to an extended care facility or started on a home health plan. Because of the wide variety of illnesses common to the aged and the frequency of combined diagnoses, this could create more problems than it would solve. It is extremely difficult and unrealistic to categorize Medicare-age patients in this manner. Therefore, we urge substitution of the language in the Senate version of H.R. 17550, Second Session, 91st Congress.

SECTION 243—PROVIDER REIMBURSEMENT REVIEW BOARD

The Provider Reimbursement Review Board, as outlined in this section supplies an adequate, workable mechanism for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination. We recommend the adoption of this provision.

SECTION 251—PHYSICAL THERAPY SERVICES AND OTHER THERAPY SERVICES UNDER MEDICARE

It is strongly recommended that the physical therapy benefit *not* be expanded to include services furnished by a licensed physical therapist in his office or in the patient's home as provided in H.R. 1 for the following reasons:

1. This provision would increase Program costs for the same services *presently* available by making these services payable on a *fee for service* basis from the physical therapist rather than a cost basis (salaried employee) from the existing outpatient physical therapy providers.

2. The objective of limiting physical therapy costs to providers to what would have been paid as salary if the services were performed by a provider's employee (contained in this same section of H.R. 1) would be frustrated. The result would be that physical therapists who had previously worked on a fee for service arrangement with a provider would terminate this arrangement in view of the pending salary type limitation and go into independent practice—thus retaining the fee for service payment with the accompanying excess costs which H.R. 1 is attempting to eliminate.

3. The existing shortage of physical therapists available to medical facilities would be increased as a result of the incentives to go into independent practice to secure the fee for service payment. The rationale here would be, why work for a salary when one could go into business for himself and greatly increase his income with Medicare providing a virtual guarantee of a market and payment for services.

4. The additional record keeping involved in keeping track of the \$100 in charges each year would be very expensive.

5. If physical therapists are allowed to treat in their office, will not the speech therapists, occupational therapists, etc., want the same privilege?

We urge adoption of the language in the Senate version of H.R. 17550, Second Session, 91st Congress.

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

This is a statement on behalf of the Health Insurance Association of America, representing a membership of over 300 insurance companies which write approximately 80% of the health insurance written by insurance companies in the United States.

We appreciate this opportunity to state our views with respect to the health care and disability aspects of the proposed "Social Security Amendments of 1971" (H.R. 1) and other legislative proposals to amend the Social Security Act which are pending before this Committee. Our statement will discuss several of the substantive amendments to Title XVIII, the Medicare Program, and will also express our concern over certain measures designed to expand the definition of disability for the purpose of qualifying for benefits under Title II, the Disability Insurance Program.

We cannot over-emphasize the fact that, regardless of the financial ability of people to pay for their health care, the services themselves are frequently not available. This involves both health manpower and facilities for care. The shortages in professional manpower are generally recognized. The need for additional para-professional manpower with skills to relieve the overburdened professionals is equally evident. In addition, licensure laws are sorely in need of revision to bring about greater uniformity and recognition of transitional developments in the health care field. Correction of these situations should be given high priority.

This nation has not adequately developed its primary care services, has not put sufficient emphasis on early diagnosis and treatment much less prevention with the result that our present health care system concentrates on costly inpatient hospital care. We need greater emphasis on more efficient and lower cost ambulatory care. The establishment of community ambulatory care centers which would be available to the practicing physician (it is estimated that perhaps 20% to 25% of the surgery now performed on an inpatient basis could be done in such a properly equipped center), the expansion of existing group practices, and the reorganization of hospital outpatient departments are examples of possible approaches. Convalescent facilities and organized home health services are also necessary to provide alternatives which are not only less expensive but more closely related to the needs of the patient.

Many of these needs have been recognized by the House-passed bill (H.R. 1). The proposals before your Committee with respect to Health Maintenance Organizations, institutional planning and budgeting, and peer review all move in the direction of dealing with certain present deficiencies.

With these efforts in mind, and with regard to our philosophy of the roles of private health insurance and government in the health care field, we now turn to a discussion of a few of the legislative proposals before your Committee.

SECTION 226—PAYMENT TO HEALTH MAINTENANCE ORGANIZATIONS

It is proposed that an alternative be provided under the Medicare Program the overall purpose of which is to encourage the development and use of the so-called Health Maintenance Organizations (HMO's). The purposes of HMO's—actually a broadening of the traditional prepaid group practice arrangements—include: (1) making more generally available to the consumer an organized means of comprehensive health care of good quality, with emphasis on preventive services; (2) bringing about a more efficient deployment of available health care manpower; (3) bringing about overall savings in expenditures for health care services, particularly for hospitals.

These are all meritorious objectives which we share. Insurance companies in fact are actively involved in a variety of ways to improve the health care delivery system, including the development of HMO's. Our companies are working intensively in a considerable number of locations throughout the nation in helping to develop prepaid group arrangements, and are seeking to experiment in various types of such arrangements.

We find this no easy task, and in all candor, must suggest to the Committee that there is no inherent magic in the HMO name, in and of itself. Clearly, however, the potential is there and should be pursued.

HMO's, to function successfully, must have active consumer interest and support. Without this they fail, as experience has shown. They must also remunerate physicians on a level and basis which will attract and hold capable physicians. If this is not the case, the quality and the comprehensiveness of the care they provide will be inadequate. They must further be located geographically so that they will be convenient to a large number of people. This means that at the same time there must be available an alternate form of insurance or protection for those to whom the HMO services are not convenient. Beyond this any expectation of cost savings should be carefully examined. Comprehensive care of good quality is costly, no matter how provided. Any proposed financial savings should not be made at the sacrifice of either comprehensiveness or quality.

While no one has developed a widely accepted definition of an HMO, we believe that whatever definition is arrived at should only include the concepts of what an HMO is to be. Any restrictions on an HMO or its operations should not be contained in the definition, but should be stated separately. We suggest that the Committee give careful consideration to such factors as we have mentioned, including: the reimbursement methods established for HMO's; consideration of the establishment by statute or regulation of standards having to do with the risk-bearing function of the HMO; the scope of services to be provided; the delivery and quality of the health care provided; and the financial stability of the HMO.

The Committee is aware that existing laws for regulation for several of the States serve to inhibit the development of HMO's. Information on the details of these restrictive measures is readily available. The Committee might well give consideration to appropriate means by which these retarding influences might be overcome.

The Committee, in addition, might want to devote special attention to those HMO's established in inner-cities or rural areas where the principal purpose is to serve the poor. It is recognized by many authorities that serving a population of various socio-economic levels is preferable to segmenting out the poor. To do otherwise jeopardizes quality and fosters second class care. Diversification of populations served should at least be permitted under the proposal, and preferably should be encouraged by positive means.

SECTION 221—LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

The need for achieving the highest level of institutional care is predicated, to a great extent, on the relation of a health care facility to the total health needs of a community. Section 221 of H.R. 1 would tie capital expenditures under the various Federal programs providing reimbursement for institutional services to the review of the planning agencies established under the "Partnership for Health" Act (Public Law 89-749).

The "Partnership for Health" approach offers a new and welcome advance in government/private industry relations. It puts the responsibility and decision-making (backed up with resources) where it properly belongs—with the States and in the local communities. Our Association endorses this concept and we are committed to support, with manpower and administrative technical skills, the planning process in all fifty States.

The planning process implies the need to relate ambulatory care, preventive health maintenance and even the quality of the environment as influencing the proper and effective utilization of our health care facilities. The cost of institutional care will never be placed in perspective until alternatives are mobilized (and adequately financed) to put the patient in the proper facility, at the appropriate time and at a reasonable cost.

In addition to its primary function of coordinating capital expenditures to sound health planning principles, the provision recognizes the potential of area-wide planning agencies and the need to reimburse such agencies for valuable services rendered to Federal health care programs.

We agree with the concept which is embodied in Section 221.

SENATE AMENDMENT NO. 823

Senate Amendment No. 823, introduced by Senator Bennett, provides for the establishment of professional standards review organizations, generally at the local level, as the primary mechanism to control and moderate the soaring cost of Medicare and Medicaid. The objective of controlling and reducing costs in

these programs is one with which we heartily concur. However, we respectfully submit that the method proposed in the Amendment to accomplish this desirable objective would be much less effective and far more costly than the alternative method we shall outline in a moment.

To be both effective and affordable, utilization review must combine the professional knowledge of the physician, the statistical data and claim processing skills of health insurance and the authority of benefit program. It would be inordinately expensive to have every claim reviewed by a physician or even a nurse. Therefore, practical utilization guidelines must be established and periodically updated by physicians with the assistance of health insurers. Insurers, including intermediaries would screen all claims against these guidelines. Claims falling within the guidelines would be paid. A small random sample of such claims would be subject to audit to assure that the guidelines were being applied properly. Claims falling outside the guidelines would be submitted to peer review. The benefit program must specify that benefits for these non-conforming claims would be paid only to the extent that the services rendered were found to be medically necessary and the charges therefore were within the limits specified by the benefit program involved.

An examination of Senate Amendment No. 823 reveals that no use is made of the expertise and data of the insurers. Figuratively speaking, the Professional Services Review Organization would have to reinvent the wheel all over again and then build and staff a new factory in which to manufacture it. This is an extravagance that no nation can afford. Senator Hansen's Bill, S. 1898, does make some advisory use of insurers; this is not enough. Therefore, we are opposed to both measures.

The approach which we recommend instead is as follows :

TITLE XVIII

Part A: In the administration of Part A of Title XVIII, utilization review committees for each provider would be selected by the provider to handle all inpatient cases. Working together, the intermediary and the utilization review committee would establish norms for lengths of stay based upon the characteristics of the community. The intermediary would refer cases which exceed the norms to the utilization review committee for review and recommendation. If, in the judgment of the intermediary, the utilization committee, including the facility administrator, is not doing its job satisfactorily, the intermediary shall give the utilization review committee 90-days notice to improve its performance. If such improvement is not made within 90 days, the intermediary shall reduce payments to the providers by 50% for a 90-day period. If at the end of that period the utilization review committee is not performing properly and effectively in the judgment of the intermediary, all payments to the provider shall be suspended until performance of the utilization review committee is satisfactory.

The intermediary, in determining the effectiveness of the utilization review committee, would be authorized to contract with medical societies, foundations, or similar organizations, to assist it in making such determinations.

A provider whose payments are suspended by the intermediary could appeal to the Secretary for review of the intermediary's decision and the Secretary shall make a final determination. The Secretary may grant a hearing to the provider.

Section 1816 of the Social Security Act should be amended to provide for the Secretary's assigning providers on a geographic basis to intermediaries for administrative purposes in the same manner that the Secretary assigns geographic areas for administration under Part B of the Medicare Program. This properly vests in the Secretary the selection and control of the intermediaries who are under contract with the government rather than the providers selecting the intermediaries. This change would strengthen the administrative effectiveness of the intermediaries and avoid the situation of allowing providers to switch intermediaries if they felt they could get more favorable administration for their facility. The Secretary should have the final determination of the effectiveness of an intermediary.

We urge Section 1861(a) of the Social Security Act be amended to remove the last clause of that section which gives to state agencies the authority to provide "consultative services to institutions, agencies, or organizations to assist in the establishment of utilization review procedures meeting the requirements of Section 1861(k) and in evaluating their effectiveness." Under present law the utilization review responsibility is split between the state agency as provided

above and the intermediary. The elimination of this clause would place the sole responsibility for determining the effectiveness of utilization review in the hands of the intermediary in order to strengthen its role in the implementation of the recommendation which we have made.

We further urge that Section 1865 be amended to eliminate the implication that the certification by the Joint Commission of Accreditation of Hospitals is evidence that the institution has a satisfactory utilization review committee. The same principle should apply to accreditation by the American Osteopathic Association or any other national accreditation body.

Part B.—Under this program, a carrier would be authorized to enter into a contract with any medical society, medical foundation, or HMO to mutually formulate norms of care and treatment based upon average patterns of practice in their particular region as principal points of evaluation and review. If a peer review committee determines that a particular physician is guilty of gross and flagrant violation of the standards and norms established, the recommendations of the peer review committee would be sent to the carrier who would forward them to the Secretary with its comments and recommendations. After notification of the physician of the findings of the peer review committee, the physician may request a hearing by the Secretary. The Secretary, after such hearings, may suspend payments to the physician if the physician has: (1) made or caused to be made any false statement or representation of a material fact in the application for payment or for determining the right to such payment; (2) has submitted or caused to be submitted bills or requests for payment containing charges for services rendered which the Secretary finds to be substantially in excess of such person's customary charges for such services; (3) has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of the individuals or to be harmful to individuals or to be of a grossly inferior quality.

The Secretary would make public the names of physicians to whom payments have been suspended so that beneficiaries would be informed concerning which suppliers could not participate in the program. The Secretary would file with the applicable state licensing authority a summary of the facts in each case and his final decision.

TITLE XIX AND TITLE V

Providers suspended under the procedure set forth under Title XVIII would also be prohibited from receiving payments from the states under Title XIX and Title V.

Since there would be some providers who would not be participating under Title XVIII but would be under Title V and Title XIX, state administrators or their fiscal agents under those two titles would be empowered to contract with utilization review committees and to contract with medical societies, medical foundations, or HMO's to mutually formulate norms for utilization and for care and treatment within a given community. The state administrator would assume the functions and powers of the Secretary as stated above under Title XVIII.

SECTION 125—WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

Over-insurance through duplication of benefits is a very serious problem now in the private insurance sector and is engaging the attention of state legislatures as well as state insurance commissioners. Everyone is sympathetic to the dismay of sickness and injury—especially in the serious and prolonged case. There is little argument over reimbursement of 80% of economic loss.

However, more than 80% reimbursement results in increased costs to others and a reduction in incentives to rehabilitation. In this instance, it threatens state workmen's compensation systems themselves.

For these reasons, we support the views of workmen's compensation insurers in opposition to this change in law.

OUT-OF-HOSPITAL PRESCRIBED DRUGS UNDER TITLE XVIII

Various proposals have been introduced which would add out-of-hospital prescribed drugs to the Medicare program. These are all based on the fact that many Medicare beneficiaries can experience hardship in paying for out-of-hospital prescribed drugs in instances where their use is frequent and therefore costly.

We generally concur, and do not oppose this type of benefit assuming a program which is soundly conceived, adequately financed, and administratively feasible is adopted.

The costs of adding prescribed drugs to the Medicare Program can be considerable. This is due in large part to heavy administration expense. Therefore, some form of patient cost-sharing is needed. This could be secured through the use of a deductible, or by a flat charge per prescription. If a deductible were to be used, we would recommend that drugs, on a reasonable charge basis, be added as a covered charge under Part B and be subject, together with the present Part B covered charges, to a single \$50 calendar year deductible and to the 20% coinsurance requirement. Regardless of the method chosen, or the financing mechanism, we would strongly urge that administration of any drug benefits be placed with the Part B carriers since they are experienced in administering all out-of-hospital benefits and in serving the beneficiary rather than the provider of care.

COMBINING PARTS A AND B OF TITLE XVIII

Another proposal which has been advanced is that the benefits of Part B of Title XVIII should be provided under Part A and combined as a single program. The result would be to eliminate the voluntary and contributory nature of the present Part B program and also produce a sharp increase in the present level of payroll tax.

The effect of this proposal upon the payroll tax is a matter which warrants serious consideration. Rising health care costs are presenting serious problems for the present financial structure of Medicare and this proposal would aggravate those pressures.

INCREASED USE OF GENERAL REVENUE FINANCING FOR TITLE XVIII

It has been proposed that the use of Federal general revenues to finance the Title XVIII program be expanded well beyond the present matching of the elderly's contributions under Part B. In the main, proposals for general revenue financing are made by those who would expand the benefits of the Medicare Program while at the same time reducing pressures for marked increases in the payroll tax. Such expansion of the benefits would be contrary to the basic concept of the Social Security Program as a floor protection for the elderly. Furthermore, the use of general revenue financing for such expansion would obscure, but not avoid, future necessary increases in the taxes to support the program.

Financing a program of health benefits primarily through readily identifiable payroll taxes or monthly premiums is particularly salutary at the time when the price of medical care threatens to continue to rise. The direct reflection of higher prices in earmarked taxes and premiums serves to focus public attention and generate positive action to curb rising prices in a way that would be obscured, to the extent that funds were drawn from general revenues. Most important, it avoids making of the program a welfare mechanism rather than the self-sustaining program originally intended under which the beneficiary has clear entitlement as a right.

For these reasons, we are opposed to the future introduction of general revenue financing in the Social Security system.

EXTENSION OF TITLE XVIII TO THE DISABLED

H.R. 1 has extended Title XVIII to cover persons entitled to disability benefits under the Social Security and railroad retirement programs provided that these beneficiaries have been disabled for at least two years. We are opposed to this extension.

The benefits which evolved under Medicare were oriented toward acute hospitalization and related services of those over 65, and not for long-term or custodial type care. Data gathered by the Social Security Administration indicate that a sizable portion of the disability insurance beneficiaries are disabled as a result of diseases of the circulatory system or mental, psychoneurotic, and personality disorders. A recent SSA report states that: "Close to two-thirds of the disability beneficiaries had severe losses in physical capacities or were functionally dependent." In addition, several thousand of the children who receive childhood disability allowances under this program suffer from diagnosed mental deficiency which requires principally educational and vocational training, and

at times custodial services. The benefits of the Medicare Program were not designed for such situations.

Another matter of importance is the cost of such an extension of Medicare benefits and how this would be financed. Estimates of such costs, which the House Ways and Means Committee put at \$1.85 Billion during the first full year of the program, can only be projected with respect to any specific proposal. In any instance, however, the costs of providing Medicare benefits to over one and a half million additional beneficiaries will be added to the present Medicare financing. The costs of present benefits alone have been rising rapidly and are a cause for concern. As an example, H.R. 1 indicates the requirement for updating the combined employer-employee hospital insurance tax rate scheduled for present Part A benefits with an ultimate scheduled tax of 2.4% to take effect in 1972 rather than the 1.8% contemplated by present law for 1987. To extend these benefits to the disabled would result in further increase in costs to the program.

A report of the Advisory Council on Health Insurance for the Disabled found no definitive data on the extent to which the medical needs of the disabled were currently unmet. The Council also found essentially no data on how the disabled are currently financing the substantial medical care the data shows they do receive. It was noted, however, that private health insurance plays a significant role in the early months of disability for most of the disabled, and, for some, continues to play an important role even after disability has lasted several years.

Since the Social Security Disability Insurance Program is predominantly an employment-centered program, it is reasonable to expect that at the onset of disability the vast majority of eventual beneficiaries would have private health insurance protection for their health care costs. Our estimates indicate, for example, that 89% of the population under age 65 have private health insurance coverage. This would be used to defray the initial costs of care, particularly such costly forms of care as hospitalization and surgery.

Under group insurance policies, benefits during disablement are made available under the group plan itself or under a conversion policy. Under many group insurance contracts, medical expense benefits are continued as long as the disability lasts or until the individual becomes eligible for Medicare, whichever occurs first. Individual policies can usually be continued after the onset of disability. Today the majority of group plans sold include major medical expense insurance with sizable maximum amounts.

Therefore, many of the disabled have a considerable degree of private health insurance protection. Extension of the Medicare benefits could only result in duplication of these coverages. We do not assert that in every instance private insurance plans go as far as might be desirable or necessary in their effectiveness, but the basic mechanism exists and continuing progress is being made in the direction of increasing effectiveness.

It is also to be noted that the majority report of the Advisory Council would provide three to five months' temporary insurance coverage each year to at least 600,000 persons whose disabilities would last long enough to qualify for the Medicare benefits but not long enough to qualify for the Social Security cash disability benefits and for whom there is no evidence of a significant unmet need. The modification of the general concept would not only further increase the costs of such an extension of Medicare benefits but would create difficult administrative problems some of which the Advisory Council recognized but did not resolve.

Principal of these is the fact that the Medicare benefits at present are of a permanent nature: that is, once becoming eligible at age 65, the individual has entitlement to such benefits for the remainder of life and need only plan for supplemental financing to the extent he considers the Medicare benefits inadequate. However, when such benefits are made available to those who are clearly temporarily disabled with expectation of returning to an active work-force status, the permanency of the Medicare entitlement ceases to exist. Termination of disability would result in termination of Medicare entitlement. Meanwhile the disabled person may have terminated his private insurance protection, and in some cases might be left with no health care protection at all, since, in the interim, it would be uneconomic for the private insurance coverages to duplicate the Medicare benefits. Such situations could only result in public dissatisfaction.

It is for the foregoing reasons that we are opposed to the extension of Medicare benefits to disability insurance beneficiaries. While there is no doubt that there are disabled individuals who need some form of government assistance

to enable them to meet their health care expenses (as is presently the case under the Medicaid Program), the extension of Medicare benefits to all disability insurance beneficiaries does not appear the most economic or desirable way of providing such assistance.

REDUCTION OF WAITING PERIOD FOR DISABILITY BENEFITS

H.R. 1 expands the definition of disability for the purpose of eligibility to receive cash disability benefits in that disability benefit payments would begin after the sixth month of disability because of a reduction of the six-month waiting period to five months.

Protection against loss of income because of disability is the oldest type of coverage in the health insurance field. At the end of 1969, 57 million wage earners had short-term protection against such loss of income through insurance company plans or other formal arrangements. Of these, over 40 million were protected by insurance companies (the proportion of the labor force with private health insurance protection has grown significantly in recent years), and the remainder by formal arrangements including sick leave plans of federal, state, and local governments, as well as private industry, unions, and plans of employee mutual benefit associations. Five states (California, Hawaii, New Jersey, New York and Rhode Island) and Puerto Rico have enacted laws placing compulsory responsibilities upon specific categories of employers for certain economic losses to employees (and to a certain extent, the temporarily unemployed) resulting from non-occupational temporary disability. In many cases, benefits continue for six months of disability.

The report of the Ways and Means Committee (p. 56) states: "Your committee's bill would reduce the waiting period for disability benefits by one month. Under present law, entitlement to disability benefits can not begin until after a worker has been disabled throughout a waiting period of six consecutive full months . . ."

"While many workers have some protection against loss of income due to sickness or disability under various public or private plans (such as group policies, sick-leave plans, etc.), such protection usually expires before the end of the present disability waiting period . . ."

The foregoing excerpt fails to justify the change. Although it does recognize that insurance companies have disability coverage (which is substantial and usually provides for the first 26 weeks of disability) it fails to recognize that its proposed change would create a duplication of benefits for the sixth month. This need, as cited by the Committee report, is due to two reasons: the delay of SSA in paying a claim, and SSA's not recognizing a disability for part of a month. Rather than reduce the waiting period, a change should be made in the Social Security legislation so that a partial month of disability will count toward the total disability period. Further, SSA should be encouraged to speed up its claims process. If a commercial insurer were to delay a payment for the same amount of time, there would be numerous complaints and most likely quick action by state insurance commissioners.

Another objection we have to the provision is that it would create a duplication of payments under State workmen's compensation laws in all cases of total disability, temporary as well as permanent, lasting 6 months or more. It would thus result in many individuals qualifying for both State statutory benefits and social security disability benefits, a combination which would often provide more in tax-free income than the individual's take-home pay while working. The resulting adverse effect upon efforts to rehabilitate such persons, in our opinion, would be contrary to the best interests of both the public and the individual.

In 1949, the Ways and Means Committee wisely took the position that "Payment of disability benefits under the Federal social security program should not restrict or interfere with the continued development of adequate workmen's compensation programs in the United States" and that "adequate safeguards should be maintained against unwarranted duplication of the two types of benefits. The total benefits payable under the two programs should not be excessive in relation to the purpose for which the benefits payments are intended." House Report 1300, 81st Congress, 1st Session (1949), page 30.

The enactment of this provision would violate the above criteria. It would remove the economic incentive for an injured worker to rehabilitate himself,

it would add unnecessary costs to social security for job-connected injury and disease, and it would hamper efforts by the several States to improve their respective workmen's compensation programs.

It has been repeatedly demonstrated that disability tends to be unduly prolonged when overinsurance exists, particularly if such benefits are payable as a matter of contractual right. If these benefits approach the level of what might be earned in active employment—and it should be remembered that we are dealing with tax-free benefits—the incentive for returning to work is lost. Likewise, the incentive for a disabled person to become rehabilitated is a great deal less in many cases. The economic incentive to return to work or to seek rehabilitation, if necessary, depends upon the margin between earnings (after deducting income taxes, union dues, and other expenses of employment) over the tax-free and expense-free amount of disability benefits available.

Any entry of the Federal Government into the temporary disability field through the liberalization of the disability definition would overlap these state programs as well as the many forms of insurance company coverages which presently protect the majority of the work force.

Insurance companies have gained considerable experience in this field and today coverages are readily available which, by any reasonable standard, are adequate protection against the hazard covered by insurance. These coverages may be purchased for groups of employees, associations of small employers, or for individuals not related to groups of people or desiring to supplement group insurance coverage. Protection can extend from a few days after the onset of disability to date of retirement. The benefit amounts can approximate the net income lost by most workers, after allowance is made for income taxes, reduced living expenses, the provision of an incentive to return to the work force or rehabilitation, and state or federal compulsory insurance benefits.

For these reasons, we oppose any reduction in the current definition of disability to encompass the temporarily disabled.

CATASTROPHE-ONLY HEALTH INSURANCE COVERAGE

The insurance business deeply appreciates the fact that Chairman Long and this Committee have drawn attention to the grave problem associated with catastrophic illness and have sought to develop an effective means to ease its financial burden.

This is a challenge which has engaged the earnest efforts of our companies since 1951. It is a matter of pride to point out that we have succeeded in making substantial inroads on the problem through the development of major medical insurance. Over the past two decades, the number of people we insure under such coverage has grown phenomenally—from a mere 151,000 in 1951 to 52 million in 1966, to well over 80 million today.

Other insurers and prepaid group practice plans also provide coverage against the overwhelming illnesses which fall unevenly on families. The numbers they insure, when added to the numbers covered by insurance companies, currently protect about half the population, some 105 million people, against the cost of catastrophic illnesses.

We appreciate this opportunity to share our experience with coverage for catastrophic expenses with this Committee and to make suggestions as to what we consider the most appropriate and effective course of action the nation can take in dealing with this and other pressing problems in the health care area.

We believe the issue to be one of priorities—of selecting where first to put the nation's resources—of how to interrelate the many lines of action demanded by the growing and complex needs of Americans for better health care.

This Committee is well aware of the many problems of health care delivery and financing facing the country, in addition to the catastrophic costs issue. There are shortages of health and medical manpower and there is a need for recruitment and training of allied health personnel to supplement and augment physicians' services. There is poor quality, inaccessibility, even total lack of adequate health care in the inner cities and rural areas. There is overemphasis on costly hospital usage, with "overbedding" in many communities and resulting inflationary pressures to fill beds. There is underemphasis on development of less expensive ambulatory and preventive care and health education which would help meet the primary health care needs of individuals and families and which frequently could avoid use of high cost hospital beds.

Our experience has firmly convinced us that these problems are intimately intertwined. In the very nature of the situation neither these specific problems nor the total problem will be solved by fragmented approaches. Every action has a reaction, and frequently the reaction exacerbates old problems and creates new ones as well. In the health field we must get to the root issues and deal with first thing first.

The "first thing first", in our view, is a coordinated, comprehensive approach to ambulatory care. This must be integrated with intensified manpower development, with an invigoration of community health planning and with greater involvement of consumers. It should be supported by a coordinated private-governmental health care financing system. This, we believe, can be soundly grounded and approached constructively and immediately through use of tax-sanctioned benefit standards—including catastrophic costs coverage—which are phased in realistically in terms of access to resources and facilities. The development of these services and facilities must be stepped up significantly, including such concepts as the "health maintenance organization" (which we have mentioned elsewhere in this testimony). Otherwise, we risk over-promising and raising expectations which simply cannot be achieved.

Private health insurers do not oppose the concept of "catastrophic coverage" nor, for that matter, do we oppose its extension and improvement, as part of a comprehensive program. We are reluctant, however, to see priority given to a fragmented approach which would deal with only a small part of the total problem and would lull the nation into delaying action necessary to deal with more significant problems in the health field.

With its heavy emphasis on inpatient hospital care, a "catastrophe-only" program would intensify the public's tendency to over-utilize hospitals—and it is virtually unanimous among medical economists that this has been one of the primary reasons for the upward trend in health expenditures in recent years. It would also divert funds needed to encourage the development of ambulatory and preventive care, and in the long run it is in this direction that not only will costs be controlled but health care made more accessible and of better quality.

A medical catastrophe is hard to define. According to S. 1376, it would be a case involving either more than 60 days of hospital confinement or more than \$2,000 of necessary medical expense apart from hospital care. This definition illustrates the difficulty, because various combinations of hospital expense and non-hospital expense could be more serious financially than one of the two tests described above; e.g., 30 days of hospital confinement and \$1,000 of non-hospital expense would easily exceed \$2,000. The Association is unaware of any satisfactory, generally accepted, definition of where the limits should be set, what items of expense should be taken into account, or what variations would be appropriate for persons at different levels of income.

Even if some acceptable method could be devised to differentiate catastrophic medical expenses from other medical expenses, the fact remains that only a small portion of the American people would ever benefit from the enactment of a catastrophe-only program. For example, any patient who has been in a hospital for 60 days will have run up at least \$5,000 in medical bills. Yet, among adults under age 65, less than two in 1,000 have a \$5,000 medical bill in any given year, and for children, the figure is less than one in 1,000.

The relatively low cost of "catastrophe-only" benefit is deceptive. Like the visible portion of an iceberg, completely hidden are the vast number of small and medium-sized bills which are screened out by the huge deductible, but which the patient must nevertheless arrange to pay. In this respect, the benefit to most people would be minimal, and the advantages would accrue mostly to the more well-to-do.

A catastrophe benefit could well generate a good deal of public dissatisfaction. Were a federally-underwritten catastrophe benefit with a fairly high deductible amount enacted for the working population, relatively few people would qualify for benefits. Expectations raised by enactment of the legislation would be disappointed, and there would be inexorable public pressure to lower the deductible. Successive reductions of the deductible with increasingly larger proportions of the total medical bill paid by the federal government would result in the nation "backing into" an extensive and expensive federal health insurance mechanism (not unlike S. 3, the Health Security Act of 1971), with little chance such a transition would be carefully thought out either with respect to the type of health care to be delivered or its costs.

Proposals before the Committee envision the "catastrophe-only" benefit being financed by a relatively modest payroll tax under the Social Security System. Social Security tax rates are now above 10 percent, which many regard as a high level. As this Committee is aware, H.R. 1, without any catastrophe benefit, calls for eventual employer-employee taxes of 14.8 percent on an ever-increasing taxable wage base that starts at \$10,200. Even though the additional taxes indicated as necessary to finance a catastrophe-only plan appear small, they may be the critical difference between an acceptable and unacceptable level of Social Security payroll taxes. This would lead to greater pressures for the use of general revenues to finance the program. Such financing would be most unwise. Now is the time to weigh the adverse potentialities.

Over 105 million Americans now have some form of catastrophe insurance in addition to basic coverage for hospital and doctor bills. Some have maxima of \$10,000 and \$20,000; many extend further to \$50,000 and \$100,000. Most of these plans have substantially lower deductibles than those contemplated by S. 1376. The scope of medical expenses covered is also broader. If Congress were to enact a high deductible, catastrophe-only benefit financed by payroll taxes, and these 105 million Americans elected to keep their present coverage in addition to the new Social Security benefits, a potential over insurance hazard would be created, and significant administrative expenses would be added to the health care system from the duplicative governmental and private program.

In practical terms, the nation is already well on the way to the goal of universal coverage for major health care costs. It would be a relatively simple matter to provide \$200,000 maximums through the use of a federal benefit standard coupled with a tax incentive, for example. The added claim cost to present health insurance would be modest, something in the neighborhood of 10¢ to 40¢ per month per adult and about half that for children.

It is our conviction that the nation deserves a comprehensive, coordinated, and integrated approach to its basic needs for health care. The Healthcare Program set forth in S. 1490, introduced by Senator McIntyre, achieves this goal. On the other hand, a fragmented approach is not in the public interest. An approach which further burdens the taxpayer for low-priority purposes is not in the public interest.

A catastrophe-only benefit would perpetuate the present two-class system of financing health care in the United States. Such a program would do nothing to cover the basic health needs for the poor. Therefore, Medicaid or some other separate government program would have to be used to pay expenses of the poor that were left unpaid by the huge deductible and the potentially large amounts of copayment. The working population, however, would continue to rely on private insurance to meet these otherwise out-of-pocket expenses. The goal of a single system for all people will be difficult to achieve. To adopt an approach that will almost certainly reinforce the dual system seems a most unwise and unacceptable course.

A "catastrophe-only" approach would, in our view, divert the nation's energies and limited resources away from more pressing issues in the health field. Conceivably, however, there may be imperatives to move now in the "catastrophe-only" direction, taking into account the almost certain and deleterious side effects.

If, on balance, this proves to be necessary, we feel it certainly would not be prudent to set up a payroll tax mechanism that would be redundant and overlapping with present private arrangements and which would almost inevitably destroy coverages now held by 105 million Americans as the result of their own initiative and responsibility, developed in cooperation with forward thinking employers.

It would be far more prudent to utilize the skill and experience of private insurers. To discard the services they offer would not be in the public interest. We offer our services, expertise, and experience to the solution of the catastrophic health costs problem.

The CHAIRMAN. Next we will hear from Ned F. Parish, president, National Association of Blue Shield Plans. Mr. Parish is not here so Mr. Knebel will present the statement.

**STATEMENT OF JAMES D. KNEBEL, EXECUTIVE VICE PRESIDENT,
NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, ACCOMPANIED
BY LAWRENCE C. MORRIS, VICE PRESIDENT, PLANNING AND
PROGRAMING, NABSP**

Mr. KNEBEL. Yes, Mr. Chairman. Mr. Parish is unable to be here.

My name is James D. Knebel and I am executive vice president of the National Association of Blue Shield Plans, and with me is Lawrence C. Morris, our vice president of Planning and Programing.

The association represents 71 member Blue Shield plans in the United States and Puerto Rico. These plans provided health care protection to over 67 million subscribers in private business in 1971 and served as carriers for another 12.5 million persons covered under Government programs.

You may recall, Mr. Chairman, we appeared before your committee on September 23, 1970, and presented testimony on H.R. 17550, the Social Security Amendments of 1970. We commented then on Health Maintenance Organizations, limits on prevailing charge levels, payment to States for installation and operation of claims processing systems, the Federal Employee Program, and several other sections of that bill. Since these provisions are retained in H.R. 1, we refer you to our earlier testimony for our comments regarding those sections.

Today we would like to comment especially on amendment 823, which would create professional standards review organizations—PSRO's—and on catastrophic illness coverage.

Mr. Chairman, amendment 823 would have physicians form corporations to review and regulate the practice of medicine. It would vest in these corporations the authority of the Government in order to control the quality and cost of services in Federal health programs.

However, we believe the amendment does not properly allocate responsibility for claims review and peer review in the utilization review process. Since the data to support the PSRO process are generated by carrier activity, the carrier system should be much more closely integrated into the review of utilization.

The carriers have acquired a large data base and sophisticated computer support to collect and analyze information about practice patterns. They also have the ability to identify normal practice patterns by specialty and geographic area, and to find significant deviations from the norm.

This information, generated by the carrier from the information it collects in reviewing claims, needs to be better utilized. Blue Shield, together with Blue Cross, is involving as key principals the following organizations to interpret and utilize these data: The organizations include the American Medical Association, the American Society of Internal Medicine, the American College of Surgeons, the American Academy of Family Practice, American College of Radiology, College of American Pathologists, American College of Obstetricians and Gynecologists, American College of Clinical Urology, American Academy of Pediatrics, American Hospital Association and the Joint Commission on Accreditation of Hospitals.

Utilization review is basic support for peer review which is professional evaluation of the quality and appropriateness of the medical services received by the patient.

Effective utilization review begins when qualified physicians examine abnormal patterns of service, render valid medical opinions in the light of the medical community's practices and customs and so advise the carrier.

It appears to us that amendment 823 misinterprets this key relationship. It calls for substantial duplication of the carrier function rather than coordination of PSRO and carrier activities in pursuit of a common goal.

The administrative costs of medicare would be increased by routing claims through a PSRO. Blue Shield spreads the cost of general administration over a wide range of programs. As proposed, however, total administrative costs of a PSRO would be charged primarily to Government programs. This includes costs associated with statistical analysis, utilization review, professional relations, and educational programs.

The amendment would also tend to motivate physicians who do not feel that their practices can bear scrutiny to refuse assignment. We do not mean to imply that there are not valid reasons for direct billing; but by billing the patient the physician would take his claim outside the cost and quality controls of the PSRO. Any denial of payment would affect the patient rather than the provider, thus defeating the principal goal of the PSRO. It would also mean that any funds tied up awaiting reimbursement of claims would be the patient's. This may well cause hardship.

The PSRO, at this point, is untested on any broad scale. Apparently, it is modeled after certain types of foundations for medical care. A substantial number of established foundations have been assisted by Blue Shield, both in the startup phase and in their subsequent operation. But they have never been tested on a national scale.

We view the PSRO, as it is conceived in this amendment, as a high risk proposition. There is virtually no risk in continuing to improve the widely tested and accepted carrier-peer review relationship now used in the better utilization review processes, especially in view of the provisions of section 222 in H.R. 1 which emphasizes further experimentation.

Section 1170 of amendment 823 also requires comment.

To the extent that government funding is used to create competitive underwriting capacity for medical organizations, the government will be creating new and duplicative Blue Shield plans. In the Blue Shield system today, we can demonstrate almost any stage of the development of the medically approved prepayment plan. Public funding to repeat this experience seems wholly redundant to us. Public funding that does nothing more than permit a new organization to build resources to compete with the existing private sector is inappropriate.

Mr. Chairman, we would now like to comment on the subject of catastrophic illness.

There is no question that catastrophic illness coverage is desirable for all of the people. Everyone should be eligible.

But there are two practical difficulties in designing a catastrophic

illness program. The first lies in the negative definition of a catastrophic illness.

An illness becomes financially catastrophic only when it involves expense that is both not covered by an existing health coverage contract and unreasonable in relation to the patient's other resources. Existing health coverage varies significantly from person to person and group to group. These variations are not really primarily the result of advertising and promotion leading to uninformed choice.

Most purchasers of health insurance programs today benefit from very sophisticated evaluation and analysis by pattern-setting major employers. Decision to expand and improve coverage involve relationships between basic coverage benefits and major medical type benefits. Some analysts would expand basic coverages to include a very broad range of provider services over very lengthy periods, leaving only truly catastrophic conditions, which are rarely encountered, for major medical type benefits. Others would reverse that approach by covering very limited amounts of care under a basic program, thereby leaving most costs for major medical reimbursement. Most groups are somewhere in between. Individuals respond similarly, although many avail themselves of multiple policies to provide additional safeguards.

The second difficulty is in the determination of what conditions are to be covered by a catastrophic program, so that the intent of the law may coincide with the needs of the people. Clearly, acute illness and injury should be covered. But what about long-term chronic care and treatment of congenital and possibly permanent physical and mental conditions? Will the government deal constructively with long-term custodial care, which is as much a social as a health cost, but which is frequently more catastrophic financially than the costs of treatment?

These are key points and central to our position on S. 1376, the catastrophic health insurance program—CHIP.

We believe the people of the United States must have effective basic health coverage before it is possible to construct a sound and equitable catastrophic illness program.

Presently, the public holds a variety of health care contracts. Some fall short of delivering what we would consider reasonable basic coverage. Others offer benefits that, in practical application, will usually exceed those offered under CHIP.

We are concerned that implementation of the program like CHIP would undermine high quality coverage.

We fear an immediate effect would be a massive scaling back by employer/employee groups to programs essentially designed to fill the CHIP deductible. This would result in a much lower quality of coverage to the individual patient. Further, it would represent a considerable transfer of funding from the private sector to the government.

Implicit in this approach is the possibility that it could evolve into a monolithic system of national health insurance. Benefits under the program could be broadened and the deductible and copayment provisions reduced, further restricting the activity of the private sector.

All these considerations notwithstanding, Mr. Chairman, catastrophic coverage is in itself a desirable goal. However, we believe that it must be considered in a broader context.

Hopefully, it will be possible to consider all health care coverage in the light of national health policy, proceeding toward well-defined objectives in an orderly system of priorities, and with a realistic consideration of costs and benefits. We envision the need for realistic minimum standards of basic coverage, privately underwritten to conserve tax revenues. Clearly, government assistance will be needed to help the less fortunate achieve this level of coverage. We would also like to see realistic requirements imposed upon participating carriers to assure that the administration of benefits is both responsible and effective. A national health policy proceeding toward these goals would take a truly broad view of health care financing. We endorse such an approach and hope that the committee will see fit to pursue it.

Before concluding my remarks, Mr. Chairman, I would like to again call the committee's attention to section 235 of H.R. 1.

This section would authorize 90 percent in Federal matching funds of a State's cost in designing, developing and installing mechanized claims processing and information retrieval systems under medicaid. To the extent that a State's present system is inadequate and it does not have access to acceptable carrier capabilities, we support this provision.

We would urge that these funds also be available for improving existing systems. However, the further provision that States which do design and implement new systems under this provision will then be eligible for 75 percent Federal matching for administrative costs instead of the present 50 percent will encourage States with adequate, acceptable systems to replace them with new systems, since over a period of time the additional administrative moneys from the Federal Government will far exceed the 10-percent investment initially required.

We would urge the committee to make clear that it is not the intent of Congress to merely increase the Federal percentage of administrative costs under the medicaid program.

Mr. Chairman, we appreciate this opportunity to appear before you and express our views.

The CHAIRMAN. Thank you very much for your statement.

(The prepared statement of Mr. Knebel follows:)

STATEMENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

PRESENTED BY JAMES D. KNEBEL, EXECUTIVE VICE PRESIDENT

Mr. Chairman, and members of the Committee, my name is James D. Knebel. I am executive vice president of the National Association of Blue Shield Plans. The Association represents 72 member Blue Shield Plans in the U.S. and Puerto Rico. These Plans provided health care protection to over 66 million subscribers in private business in 1970, and served as carriers for another 13.5 million persons covered under government programs. On behalf of their private subscribers, Blue Shield Plans paid out \$2.2 billion in benefits in 1970. Government program administration accounted for an additional \$1.7 billion, for a total claims volume of \$3.9 billion.

Today, we want to offer the Committee some thoughts that have grown out of our experience both in the private financing of health care, and in administering Medicare.

We would like to comment especially on Amendment 823, which would create Professional Standards Review Organizations, and on catastrophic illness coverage.

You may recall, Mr. Chairman, that we appeared before your Committee on September 23, 1970, and presented testimony on H.R. 17550, the Social Security Amendments of 1970. We commented then on Health Maintenance Organizations, limits on prevailing charge levels, payment to states for installation and operation of claims processing systems, the Federal Employee Program, and several other sections of that bill. Since these provisions are retained in H.R. 1, we refer you to our earlier testimony for our comments regarding those sections.

At that time, we also testified on Professional Standards Review Organizations. Today, we would like to amplify that testimony by commenting on Amendment 823.

Mr. Chairman, Amendment 823 would have physicians form corporations to regulate the practice of medicine. It would vest in these corporations the authority of the government in order to control the quality and cost of services in federal health programs.

To the extent that this represents an attempt to get maximum use from the health dollar, it is a commendable goal, and one worth pursuing.

However, we believe the amendment does not properly allocate responsibility for claims review and peer review in the utilization review process. It does not place the logical role of the carrier in its proper perspective in the claims review process. Since the data to support the PSRO process are generated by carrier activity, the carrier system should be much more closely integrated into the review of utilization.

Utilization review is still a developing discipline. There is a great deal still to be learned about making it effective. Any large-scale commitment to utilization control must take this into consideration.

One of the things we have learned over the years is that utilization review is a product of both claims review and peer review.

Peer review and utilization review are not synonymous terms. They should not be confused.

Utilization review is an effort to achieve the optimum balance between dollars spent for health care and the care itself. Its effectiveness depends on two elements. The first is claims review. This requires a large data base and sophisticated computer support to collect and analyze information about practice patterns. It also requires an ability to identify normal practice patterns by specialty and geographic area, and to find significant deviations from the norm. This information should be generated by the carrier from the information it collects in reviewing claims.

The second element of utilization review is peer review, which is professional evaluation of the quality and appropriateness of the medical services received by the patient. Only physicians are qualified to make this judgment, and for this reason, they must be involved in peer review.

Effective utilization review occurs when qualified physicians examine abnormal patterns of service, render valid medical opinions in the light of the medical community's practices and customs, and so advise the carrier.

The key point is that while peer review always requires professional judgment, it can be effective on a large scale only when it is supported by the technical function of claims review. The ideal is to identify from the mass of unrefined data what the physicians can profitably review.

It appears to us that Amendment 823 misinterprets this key relationship. It calls for substantial duplication of the carrier function rather than coordination of PSRO and carrier activities in pursuit of a common goal.

It would have the PSRO develop and maintain technical information that is better developed by the carriers. A more efficient way to handle the review functions is to have the carrier identify and isolate irregular claims and refer them to the PSRO. The PSRO should review the information, evaluate the medical appropriateness of the claim, and deny or affirm payment. Apparent or suspected abuse by a specific provider will lead to prepayment control of his claims, or to suspension of payments until the problems are resolved. This approach is used successfully by many Blue Shield Plans.

The administrative costs of Medicare would be increased by processing claims through a PSRO. Blue Shield spreads the cost of administering Medicare over a wide range of programs because Plans usually process Medicare claims and other lines of business on the same equipment. Thus, the equipment is doing multiple duty, which distributes the administrative costs over many projects. The administrative cost of a PSRO would be charged primarily to government

programs, resulting in an increase in costs. The amendment also would have the PSRO do initial claim review.

Apparently this means that physicians will screen every claim that comes through the PSRO. We think this is a fundamental impossibility, but, if it is true, it is a waste of already scarce physician talent. If, as seems more likely, the claims will be screened by clerical personnel and the exceptions passed on to the physician for review, then this largely re-creates the claims processing procedure now being done by Blue Shield.

We believe that much greater cost-effectiveness would result from directing additional funding toward improving carrier systems and post-payment PSRO review. Funds spent in this way would yield greater improvement of utilization review because the necessary basic expenditures—rent, furniture, EDP equipment and manpower—have been made. To the extent that functions are diverted to the PSRO, there would necessarily be some duplication of these items.

The Amendment could also discourage the acceptance of assignments by physicians. If there were unreasonable delays in processing, physicians might refuse assignment and bill the patient directly, simply to be paid more quickly. By billing the patient, the physician would take his claim outside the cost and quality controls of the PSRO. Any denial of payment would affect the patient rather than the provider, thus defeating the principal goal of the PSRO.

It would also mean that any funds tied up awaiting reimbursement of claims would be the patient's. This may well cause hardship.

We have tried to show, Mr. Chairman, that Amendment 823 would disrupt the proper relationship of claims review and peer review.

The PSRO, at this point, is untested on any broad scale. Apparently, it is modeled after certain types of foundations for medical care. We would add that a substantial number of established foundations have been assisted by Blue Shield, both in the start-up phase and in their subsequent operation. But they have never been tested on a national scale.

What if a substantial number of the PSRO's fail? What will be the cost in direct expense and uncontrolled utilization to re-create carrier capacity to control utilization? How long can we realistically maintain the cost of a stand-by condition pending the success or failure of the PSRO?

The Committee must recognize that the PSRO, as it is conceived in this Amendment, is a high-risk proposition. There is virtually no risk in continuing to improve the widely tested and accepted carrier—peer review relationship now used in the better utilization review processes.

The Department of Health, Education, and Welfare is now experimenting with a form of PSRO through its Experimental Medical Care Review Organization (EMCRO) program. HEW has made several grants to medical organizations to establish improved review processes. The results, as yet, are not in. But it would seem appropriate to get those results and evaluate them before committing all government programs to what is now an untested concept.

Blue Shield does recognize the desirability of promoting more effective utilization review in Medicare. Section 222 of H.R. 1 permits the Secretary to experiment with various methods of utilization review, presumably including the PSRO. We think this is a laudable provision and we endorse it.

The Section calls for experimentation to achieve demonstrable results. It also would permit experimentation with parallel methods in controlled circumstances. We think this type of activity should be encouraged.

There is, however, one caveat to be raised. To the extent that government funding is used to create competitive underwriting capacity for medical organizations, the government will be creating new and duplicative Blue Shield Plans. Our whole origin and history is a record of what happens to this approach over a 30-year span. The introduction of consumer representation is inevitable and desirable, although it occurs at different rates in different circumstances. In the Blue Shield system today, we can demonstrate almost any stage of development of the medically-approved pre-payment plan. Public funding to repeat this experience seems wholly redundant to us. Public funding that does nothing more than permit a new organization to build resources to compete with the existing private sector is inappropriate.

Mr. Chairman, we would now like to comment on the subject of catastrophic illness.

There is no question that catastrophic illness coverage is desirable for all of the people. Everyone should be eligible.

But there are two practical difficulties in designing a catastrophic illness program. The first lies in the negative definition of a catastrophic illness. An illness becomes financially catastrophic only when it involves expense that is both not covered by an existing health coverage contract, and unreasonable in relation to the patient's other resources.

The second difficulty is in the determination of what conditions are to be covered by a catastrophic program, so that the intent of the law may coincide with the needs of the people. Clearly, acute illness and injury should be covered. But what about long-term chronic care and treatment of congenital and possibly permanent physical and mental conditions? Will the government deal constructively with long-term custodial care, which is as much a social as a health cost, but which is frequently more catastrophic financially than the costs of treatment?

These are key points, and central to our opposition to S. 1376, the Catastrophic Health Insurance Program (CHIP).

We believe the people of the U.S. must have effective health coverage before it is possible to construct an equitable catastrophic illness program. Presently, the public can choose from among a variety of health care contracts. Some fall short of delivering what we would consider reasonable basic coverage. Others offer benefits that, in practical application, will usually exceed those offered under CHIP.

To illustrate, Blue Cross offers hospital contracts for 365 or more days of hospitalization. The 365 day contract is the most widely held certificate in 29 Blue Cross Plans. In actual practice, it very nearly matches the unlimited hospitalization provisions of CHIP. However, unlike CHIP, it requires no payment by the patient.

Blue Shield's most widely held national account coverage provides payment in full, in most instances, for surgery, including assistant surgeons; anesthesia; laboratory and x-ray services in or out of the hospital; in-hospital medical care; maternity; accidents and medical emergencies; consultations and physical therapy. These items are covered without deductibles or co-payment.

Additional benefits are available which, with Blue Cross, provide coverage for essentially the whole range of medically necessary services, although some of these are ordinarily covered on a co-payment and deductible basis, with dollar limits at the \$25,000-\$50,000 level. Approximately half of all Blue Shield subscribers carry supplemental benefits.

The point is that there is some very fine coverage in force in the private sector. This can be illustrated in terms of a federal employee program subscriber whose case has determined in the past year. Over a period of nearly seven years, the subscriber suffered from disease of the urinary tract, coupled with renal failure. Blue Cross and Blue Shield paid a total of \$109,823.23, of which \$107,356.23 was paid from basic coverage, with no deductible, no coinsurance, and no dollar maximum. No payment was required from the subscriber's pocket for these services. An additional \$2,467 was paid by supplemental benefits, after a reasonable deductible and co-payment had been incurred.

Mr. Chairman, there is really no doubt that this illness was catastrophic physically and emotionally. However, despite very high medical costs, the medical costs themselves were not catastrophic because of the quality of the subscriber's basic coverage. We can provide other comparable examples.

We are concerned that implementation of the program like CHIP would undermine high quality coverage of this type without providing a comparable substitute.

We fear an immediate effect would be a massive scaling back by employer/employee groups to programs essentially designed to fill the CHIP deductible. This would result in a much lower quality of coverage to the individual patient. Further, it would represent a considerable transfer of funding from the private sector to the government. This would be done with no real effort to direct public dollars to where they are really needed. Even if private sector contributions were spent on complimentary coverage for the CHIP co-payment—which alone could represent formidable costs to the individual—the government would be substituting public funds for private expenditure on an unnecessary scale.

We also fear that new benefit development would be severely inhibited. As new therapies emerge, a practical affect would be to load ever-increasing percentages of the health care dollar on to the public sector.

The administration of health benefits would be vastly complicated by CHIP, since it would be necessary to record costs to establish eligibility for essentially

the whole population. We would expect a much greater percentage of providers to begin billing the patient directly, causing, at best, economic inconvenience and at worst, hardship. It would be extremely difficult for the provider to know, in the case of a seriously ill patient, at what point the liability lay with the carrier, the federal government, or the patient. The natural tendency will be to look to the patient for payment expecting him to keep track of his own eligibility for reimbursement, if any.

Implicit in CHIP is the possibility that it could evolve into a monolithic system of national health insurance.

Benefits under the program could be broadened, and the deductible and co-payment provisions reduced, further restricting the activity of the private sector.

If this occurs, CHIP could reshape the nation's pluralistic and basically voluntary mechanism for financing health care into a single monolithic system. The possibility underscores the need to raise questions concerning the funding of the program, the availability of managerial and technical competence to administer it, the centralization of the decision-making process, and the long-term effect of CHIP on utilization and costs.

All these considerations notwithstanding, Mr. Chairman, catastrophic coverage is in itself a desirable goal. However, we believe that it must be considered in a broader context than CHIP.

Hopefully, it will be possible to consider all health care coverage in the light of national health policy, proceeding toward well-defined objectives in an orderly system of priorities, and with a realistic consideration of costs and benefits. We envision the need for realistic minimum standards of basic coverage, privately underwritten to conserve tax revenues. Clearly, government assistance will be needed to help the less fortunate achieve this level of coverage. We would also like to see realistic requirements imposed upon participating carriers to assure that the administration of benefits is both responsible and effective.

At that point, consideration of catastrophic coverage will become more feasible. Even then, the relationship between catastrophic and the basic coverage should be dynamic, to accommodate a continuing improvement of the minimum standards; to provide incentive for better levels of health protection; and to provide flexibility for new developments in health care.

A national health policy proceeding toward these goals and would take a truly broad view of health care financing. We endorse such an approach, and hope that the Committee will see fit to pursue it.

Mr. Chairman, we appreciate this opportunity to appear before you and express our views.

The CHAIRMAN. The next witness will be Bernard R. Tresnowski, senior vice president for Federal programs, Blue Cross Association.

STATEMENT OF BERNARD R. TRESNOWSKI, SENIOR VICE PRESIDENT FOR FEDERAL PROGRAMS, BLUE CROSS ASSOCIATION

Mr. TRESNOWSKI. I appear here today in behalf of the Blue Cross system to present our comments on H.R. 1, the 1972 Amendments to the Social Security Act, and additional amendments your committee has under discussion.

I have prepared a detailed statement of our views which I would like to submit for the record and your consideration.

To save the committee's time, I will briefly summarize our statement:

Basically, we agree with the provisions of H.R. 1 which deal with benefit improvement and administrative effectiveness; however, there are other broad health objectives to be served by this proposed legislation on which we offer the following comments and recommendations:

We support the inclusion of disabled social security beneficiaries under title XVIII and recommend that benefits for the disabled be designed to emphasize rehabilitative and vocational services.

We support the provision concerning hospital insurance for the uninsured, age 65 and over, and changes in the basis for computing part B premium charges that take into account the relatively fixed income of the aged. We also support the increase in lifetime reserve days and advocate the replacing of deductibles under part A and part B with copayments.

We recommend that the 3-day qualifying stay be retained to support the existing policy of the program on covered levels of care as they relate to home health care service.

We support the provision concerning the extension of medicare coverage for out-of-hospital prescription drugs.

However, the administrative problems inherent in the financial arrangements of the program, including cost reporting and audits, require a significant leadtime of at least 14 to 18 months before implementation and we ask there be a 14- to 18-month period before effectiveness of that provision.

Also, the drug amendment does not provide a basis for a pharmacy to seek full collection of the pharmacy charge prior to confirmation of eligibility. Thus, a good-faith provision should be in the bill providing at least full payment of an initial prescription charge prior to announcement through administrative channels of invalid beneficiaries.

Finally, the amendment should include a provision to reimburse nonparticipating pharmacies under emergency conditions on the basis of assignment, with the pharmacy accepting the allowed cost and 75 percent of the lowest filed fee as payment in full.

Blue Cross would support a catastrophic program which is linked with a broad program of basic benefits. However, unless the coverage is part of a basic benefit, it would be administratively complicated, inflationary and would fail to support necessary controls and incentives directed at providers and carriers alike.

Failure to define a strong basic coverage level would be a serious mistake in light of the total strategy needed to deal with health care problems. Without it, a freestanding catastrophic program would be an incentive for some carriers to perpetuate unrealistically low basic benefit levels.

A variation in or absence of basic coverage also would present significant recordkeeping problems for beneficiaries and the administrator of the program would have to create data systems and administer provider standards and cost reporting of a magnitude far beyond the benefits provided. We recommend that a program of catastrophic coverage be designed to supplement basic benefits and controls through premium payments by those enrolled in approved basic private programs, including medicare and medicaid. We further recommend that the catastrophic coverage begin after receipt of the approved basic benefits followed by a reasonable deductible or copayment and that the benefit be designed so as not to duplicate the basic program.

There are a number of provisions in H.R. 1 designed to deal with problems of provider reimbursement under medicare and we support most of them as important improvements in medicare reimbursement. There are, however, several provisions relating to provider reimbursement which need modification to assure that their intent is realized.

Section 223 which places a limitation on allowable costs under medicare will help to identify and more clearly define unreasonable cost. However, we urge the use of overall cost ceilings for each provider rather than ceilings on elements of cost. Section 232 allows States to develop their own methods of hospital reimbursement under medicaid. However, the method selected should assure definition of the economic cost to be paid by the purchaser and through such definition permit uniform cost reporting and audit systems.

Section 243 established a Federal medicare provider reimbursement board. The Blue Cross Association has had a successful medicare provider appeal committee since medicare began. The committee's success gives cause to question the necessity for establishing a national review board, which would seem to be a duplication of effort and expense. We would, however, support section 1878(e) of this proposed amendment which provides judicial review of a reimbursement determination.

We suggest that it does not go far enough. We would provide complete and full judicial review regardless of the action by the Secretary of HEW.

In the area of utilization review, several provisions of H.R. 1 are designed to improve some deficiencies in the programs as they relate to the control of use of service and we support most of those provisions. We recommend, however, that section 228, which provides for advance approval of extended care and home health coverage under medicare, be amended to assure that physicians whose reliability in certifying patient need is questioned, be granted the opportunity for notice and hearing.

The Professional Standards Review Organization, PSRO, is provided for under section 222. The PSRO provision passed by the Senate in 1970, while recognizing existing programs, ultimately requires national application of one form of peer review for social security programs. We have reservations about any one form of peer review fitting the entire country. The relative role of the PSRO, carriers and institutional providers must be more realistically appraised and designed to reinforce the strengths of participants. To limit the primary role to the PSRO whereby beneficiaries of the various titles of the Social Security Act are removed from peer review activities of institutional providers and carriers would seriously diminish the effectiveness achieved through review programs serving both public and private beneficiaries and subscribers.

We support the provision in H.R. 1 authorizing the Secretary to experiment with utilization review and peer review systems to evaluate and assure that peer review programs use the relationship between the medical profession, institutional provider and carriers in a unique way.

Monitoring the performance of the medicare and medicaid programs is presently a major responsibility of several Government agencies through a multiplicity of processes which consume a significant amount of administrative costs. The Inspector General apparently would be an additional review activity to these existing programs, to further identify performance defects.

We would recommend that instead of an Inspector General, the Secretary of HEW be authorized to establish within the health com-

ponent of HEW an internal management mechanism designed to strengthen the internal authority of the Secretary by translating health goals into management objectives and monitoring those held accountable for achieving those objectives.

We support the HMO concept as a viable alternative form for delivery and financing of health services and suggest that the HMO definition be strengthened so that HMO development will fully utilize consumer involvement in planning and organizing delivery of services and certain operational standards, such as use of centralized medical records, sharing of records, major equipment and technical and administrative staffs, will be encouraged in participating medical groups.

We also urge that all HMO's receive payment for 100 percent of average cost rather than 95 percent with the stipulation that each contacting HMO advise the Secretary annually as to how that payment is applied and how savings beyond actual cost shall be used. We recommend that wherever possible excesses be applied toward expanded benefits beyond medicare A and B services, reduction of subscriber premium costs and the establishment of a contingency reserve, in that order.

We also suggest that there be a provision requiring institutional and physician risk sharing within medicare-contracting HMO's and that aspects of the provision concerning reimburseable service be revised to specify clearly that the HMO make formal arrangements for both out-of-area emergency and out-of-area maintenance therapy to medicare subscribers.

Also, we support the need for controls to guard against selective cancellation of high-risk subscribers by HMO's.

We support the need for a greater Federal role in establishing benefits, eligibility and financing in the medicaid program.

We also support several provisions in H.R. 1 which are specifically designed to deal with some of the problems in the structure and financing of medicaid. They include section 207, to establish incentives for States to emphasize comprehensive health care; section 237, to establish utilization review requirements for medicaid providers; section 239, to assist in coordinating provider approval programs; and section 235, to provide financial assistance to the States for development and operation of claims-processing and information-retrieval systems.

The problems of medicaid are fundamentally the problems of the health care system. The overall goal should be to amend the medicaid program as part of a strategy to improve health delivery as well as the financing system. The challenge is to assure that enlargement of the Federal role, whether through greater financing or regulation of benefits and eligibility, contributes to improving access to care for those who need it while promoting improvements in the productivity of health services.

Mr. Chairman, we appreciate the opportunity to present our views to your committee today and we look forward to continuing to work together with Government and others to assure that adequate health care is provided to each and every American.

Thank you.

(The prepared statement of Mr. Tresnowski follows. Hearing concludes on p. 2757.)

STATEMENT OF THE BLUE CROSS ASSOCIATION PRESENTED BY BERNARD R.
TRESNOWSKI, SENIOR VICE PRESIDENT

Mr. Chairman, my name is Bernard R. Tresnowski. I am senior vice president of government programs for the Blue Cross Association, the national organization of Blue Cross Plans. I appear here today on behalf of the Blue Cross system to present our comments on H.R. 1, the 1972 amendments to the Social Security Act, and additional amendments your committee has under discussion.

Blue Cross has a vital interest in this legislation because of the major role we play in the Medicare and Medicaid programs, and our significant role in the private market.

Blue Cross serves the vast majority of the more than 20 million elderly Americans covered by the Medicare program. Since Medicare began on July 1, 1966, the Blue Cross system has processed approximately 60 million claims and handled payment of more than \$18.5 billion in benefits for the program's beneficiaries. As fiscal intermediary, Blue Cross serves 91 percent of the nation's hospitals, 88 percent of the home health agencies and 52 percent of the extended care facilities participating in Medicare.

Blue Cross has a major commitment to meeting the health care needs of our nation. We serve more than 95 million Americans in both public and private programs, for whom we made payment in 1971 of an estimated \$13.6 billion in health care benefits. As our work load and responsibilities have grown, so has our expertise in providing health benefits. Also, the scope of our concerns and activities has expanded to include participation in new programs such as Model Cities and Neighborhood Health Centers, and we have strengthened and furthered our work in the areas of benefit expansion, areawide planning, utilization review and other cost control activities.

In fulfilling our duties and responsibilities for the health of the American people, we at Blue Cross have welcomed the opportunities to assist Congress—through testimony to various committees—in developing and amending legislation on major health programs.

Specifically, we have testified on various portions of this bill when it was reported to the Senate in 1970 as H.R. 17550. Basically, we agree with the provisions in H.R. 1 which deal with benefit improvement and administrative effectiveness. However, there are other broad health objectives to be served by this proposed legislation, on which we should like to offer the following comments and recommendations.

THE HEALTH CARE OBJECTIVES OF H.R. 1

The provisions in H.R. 1 concerning Medicare and Medicaid are designed to correct some of the deficiencies in the operation and/or administration of the programs. Our analysis of the provisions indicates that they have a far-reaching effect on health care delivery and financing in general and that they are best evaluated within a broad context. In essence, provisions should be judged not only in terms of their impact on a given program or sub-program, but on the evolutionary strategy of improving access to and efficiency of service for the total population. I should like to comment on various benefits changes proposed, including catastrophic coverage and drugs under Medicare, the bill's objectives for improving operating effectiveness, with special reference to provider reimbursement, utilization review and claims administration, and the provision for a professional standards review organization, referring to the amendment submitted by Senator Bennett.

Because of their relationship to controls and incentives, we have recommendations on the health maintenance organization provisions in H.R. 1, including Section 240, which concerns the relationship between Medicaid and Comprehensive Health Care programs.

Finally, we understand that the committee will be considering significant changes in the Medicaid program to establish a federal level of benefits, federally financed for cash assistance recipients, administered through a federal agency. We shall provide comments on a federal Medicaid program, relating them to various provisions in H.R. 1 that consider deficiencies in the present Medicaid program.

BENEFIT CHANGES

We support the inclusion of disabled social security beneficiaries under Title XVIII. However, it should be noted that Medicare benefits are primarily designed for the care of acute illness and minimal after-care with extended care

and home care provisions supportive of acute in-hospital care. Yet, the severely disabled require management of the total continuing needs of their medical, psychological, social and vocational status. Necessary services often include nursing, physical therapy, occupational therapy and speech therapy, as well as social and psychological services. These needs of the disabled are most evident during the episode of illness coincident with the disabling condition.

We recommend that benefits for the disabled be designed to emphasize rehabilitative and vocational services.

In addition, health care institutions generally are not geared to the task of medical management of the severely disabled person's needs. At present there are about 400 medically oriented rehabilitation facilities in the U.S., of which about 70 have been accredited by the Commission on Accreditation of Rehabilitation Facilities of the Joint Commission of Accreditation of Hospitals. Manpower, such as rehabilitation oriented physicians, physical therapists, occupational therapists and speech therapists, is in short supply and its availability is fragmented. The financing of a benefit program for the disabled must take into account the need to influence on a parallel path the availability and organization of facilities, services and manpower to provide effective care for disabled beneficiaries.

We support the provision concerning hospital insurance for the uninsured, aged 65 and over, and changes in the basis for computing Part B premium charges that take into account the relatively fixed income of the aged. We also support the increase in lifetime reserve days, but would urge the committee to consider eliminating deductibles under Part A and Part B, replacing them with copayments. Use of deductibles should be limited to high volume, low cost items where the cost of administering the benefit is excessive when compared with the cost of the benefit. The application of deductibles to the Medicare program has resulted in a significant number of administrative complications.

The requirement of a qualifying 3-day hospital stay prior to extended care services or Part A home health benefits has been a subject of concern since enactment of the Medicare Law in 1965. The concern has focused on the possibility that unnecessary hospital use would result from the 3-day requirement. There has been no evidence, however, that Medicare beneficiaries have been admitted unnecessarily to qualify them for ECF or HHA benefits. Also, the Medicare benefits and the guidelines for administering these benefits have established that ECF and HHA services are an extension of an acute episode of illness requiring hospitalization. The Part B home health benefit does not require a qualifying hospital stay and as such does meet the needs of illness not requiring hospital care.

We recommend that the 3-day qualifying stay be retained to support the existing policy of the program on covered levels of care as they relate to home health care service.

COVERAGE OF DRUGS

We support the provision concerning coverage for out-of-hospital prescription drugs. The provision for such coverage is comparable to the current Blue Cross and Blue Shield benefit provided to the United Auto Workers and other groups. These features include:

1. A copayment for each prescription by the consumer.
2. Participating agreements with a qualified pharmacy to provide a full range of pharmaceutical services for beneficiaries.
3. A reimbursement mechanism which includes a professional fee component designed to cover the costs of pharmaceutical services rendered.

We agree with the structure of the extension of Medicare coverage for out-of-hospital prescription drugs since it follows a format which has been successful for Blue Cross and Blue Shield Plans on a national basis. Our benefit formulation was designed with two major principles in mind:

1. the existing physician-pharmacist-patient relationship must be maintained
2. the benefit must be a service program.

Our prototype program does not limit coverage to maintenance, chronic use medications, or drugs which could be used only by an individual age population; rather, all prescription drugs, plus insulin are covered. A reasonable compendium of approved drugs should meet these criteria. Under our program each prescription, whether new or refill, may contain up to a maximum of a 34-day supply with the exception of several drugs which may contain 100 unit doses. The amendment's provision to assign the responsibility for administering this benefit to the intermediary capitalizes on its assets and the experience gained in cost reporting and audits.

The financial arrangements of the program outlined in the amendment call for the purchaser of a prescription to pay the pharmacy a copayment.

If the pharmacy participates as a provider the remaining amount due the pharmacy is equal to the cost allowance for the drug, plus a professional fee. The basis for determining the professional fee through filing a statement of fee and submitting cost justification is an acceptable program. However, the administrative problems associated with this procedure including cost reporting and audits require a significant lead time of at least 14 to 18 months before implementation. There are over 60,000 retail pharmacies in the United States with limited cost analysis capability. Our experience under Medicare with institutional provider cost reports and audits has taught us to prepare adequately in advance of program implementation.

The amendment does not provide a basis for a pharmacy to seek full collection of the pharmacy charge prior to confirmation of eligibility. Under the circumstances, in the receipt of pharmacy services, eligibility determination must rest on careful checking of the prescription and beneficiary HIB identification which then must be accepted in good faith. Under these circumstances a "good faith" provision should be in the bill providing at least full payment of an initial prescription charge prior to announcement through administrative channels of invalid beneficiaries.

Finally, the amendment should include a provision to reimburse non-participating pharmacies under emergency conditions. We recommend this payment be on the basis of assignment, with the pharmacy accepting the allowed cost and 75 per cent of the lowest filed fee as payment in full.

CATASTROPHIC COVERAGE

Traditionally, Blue Cross has developed strong basic programs of benefits covering as many facets of health care as purchasers could afford and providers could deliver. These broad, basic programs spread preventive and early treatment costs among many people, resulting in fewer subscribers needing "catastrophic" benefits. Programs such as the Blue Cross and Blue Shield high option Federal Employee Program coverage, our program for the Automobile Workers and Parts A and B of Medicare without deductibles or coinsurance represent the types of basic programs that must underlie or form the basis of any sound health care benefit package.

Where catastrophic coverage or major medical benefits have been developed, they are linked with continuity of care, the administrative structure and provider controls of basic benefits. For example, the FEP Supplemental Benefits are designed to mesh with the administration and controls of the basic program. Given a similar design, Blue Cross would support a catastrophic program which proposes to spread the risk of very expensive services for a relatively few among a large number of persons. While few people utilize \$25,000 worth of kidney dialysis or undergo open heart surgery, the impact upon persons who do is truly "catastrophic". Such extraordinary expenses should be made subject to prepayment. However, unless the coverage is part of a basic benefit, it would be administratively complicated, inflationary and would fail to support necessary controls and incentives directed at providers and carriers alike.

Specifically, the catastrophic coverage provision passed by the Senate in 1970 did not require a basic program before the \$2,000 and/or 60 hospital day threshold was reached. Failure to define a strong basic coverage level would be a serious mistake in light of the total strategy needed to deal with health care problems. Without it, a free-standing catastrophic program would be an incentive for some carriers to perpetuate unrealistically low basic benefit levels. Given the price levels of health care services, any program which discourages broad basic coverage would be a disservice to the consumer.

The inclusion in the catastrophic provision of Medicare controls through provider reimbursement regulation and utilization review requirements would not be effective. While reimbursement to providers (under Medicare regulation) above the deductible would be at "reasonable cost" and "reasonable charge" levels, there would be little incentive for controls over the out-of-pocket, first-dollar liability of the patient.

The administrative problems associated with a free-standing catastrophic program also would be considerable. A variation in or absence of basic coverage would present significant record-keeping problems for beneficiaries. They would

have to keep detailed records to know when benefits would apply. In addition, the administrator of the program would have to create data systems and administer provider standards and cost reporting of a magnitude far beyond the benefits provided. All of that administrative effort might be unrelated to data concerning first-dollar coverage.

We recommend that a program of catastrophic coverage be designed to supplement basic benefits and controls through premium payments by those enrolled in approved basic private programs, including Medicare and Medicaid. We further recommend that the catastrophic coverage begin after receipt of the approved basic benefits followed by a reasonable deductible or copayment and that the benefit be designed so as not to duplicate the basic program.

IMPROVING OPERATING EFFECTIVENESS

Provider reimbursement

Blue Cross previously has testified before this committee concerning the problems of provider reimbursement under Medicare; identifying major problems arising out of the method of allocating costs to the program (ratio of charges to charges applied to costs) and citing the absence of effective incentives to limit cost increases. There are a number of provisions in H.R. 1 designed to deal with those problems and we support most of them as important improvements in Medicare reimbursement. These provisions include limitations on payment for disapproved capital expenditures, payment for services in the teaching setting, the amount of payment where customary charges furnished are less than reasonable cost and the payment for physical therapy and other services under Medicare.

Although none of those provisions deals with difficulties in allocating cost under the program, the provision for experiments in prospective reimbursement will support the need to make changes in the Medicare reimbursement system when an effective alternative is found. There are, however, several provisions relating to provider reimbursement which need modification to assure that their intent is realized.

Section 223 which places a limitation on allowable costs under Medicare will help to identify and more clearly define unreasonable cost. Prospective application of those limitations will help providers understand their need and purpose. However, we urge the use of overall cost ceilings for each provider rather than ceilings on elements of cost. The application of an overall ceiling would permit variations in cost components—i.e., acknowledging that there are several roads to effective management—and would apply an effective control on extraordinarily high costs resulting from consistently low occupancy rates or other factors related to inefficiency in producing services. We further note that the Price Commission's recently promulgated guidelines for health care providers relate to total price and cost comparisons. Ceiling limitations on total costs, either prospectively applied or imposed on incurred cost, help control costs while recognizing management variation in seeking efficiency.

Section 232 allows states to develop their own methods of hospital reimbursement under Medicaid. We agree that it is desirable to allow flexibility in reimbursement methods, such as RCC, per diem or other options which may be equitable to the purchaser and the provider of care. Such flexibility with built-in evaluation will encourage innovation which is particularly important with our present lack of certainty as to the best method. Furthermore, any given method can be validated ultimately only by comparison with contrasting methods.

However, the method selected should assure definition of the economic cost to be paid by the purchaser and through such definitions permit uniform cost reporting and audit systems.

Section 243 establishes a federal Medicare provider reimbursement board. The Blue Cross Association has had a successful Medicare provider appeal committee since the beginning of the Medicare program. As of January 19, 1972, the committee has published 72 decisions and its staff had administratively resolved another 35, for a total of 107 appeal requests resolved. In addition to the settled appeals, approximately 60 appeals are pending hearing or administrative resolution. Currently, we hear 8 to 10 appeals per month. The procedures of the committee have been approved by the Social Security Administration and its functioning has been commended by the provider associations involved. The committee's success gives cause to question the necessity for establishing a

national review board. Additionally, HEW, on January 5, 1972, published Regulations Sections 405.490-405.499 (f) proposing the establishment of hearing procedures for all intermediaries. The establishment of a national board would seem to be a duplication of effort and expense.

However, Section 1878(e), which provides judicial review of a reimbursement determination is necessary, but does not go far enough. It should provide complete and full judicial review regardless of action by the Secretary of HEW.

As to other sections of the provision, we note the following:

Section 1878(a) (1)—This section states that a provider may request a hearing if it "is dissatisfied with a final determination of the organization serving as fiscal intermediary". We feel that the provider should be required to exhaust all administrative remedies before appealing to the national review board. Such administrative remedies should include procedures approved by SSA for the Blue Cross system and the procedures utilized in Regulations Sections 405.390-405.499 (f).

(a) (2)—This section defines the jurisdictional amount in controversy as \$10,000 or more. There should be further clarification of the \$10,000 amount to restrict it to \$10,000 or more of reimbursable cost, not of total allowable cost.

(b)—Neither in this subsection nor in the remainder of Section 1878 is provision made for participation by the intermediary as a party to the proceedings. The participation of the Blue Cross Plan as a party to our present appeal procedures. Both the intermediary and the provider must be represented at the hearing as adverse parties to insure the full disclosure of facts, including necessary audit information available only to the intermediary. The lack of representation by the intermediary will leave a gap in documented evidence needed by the board to reach a fair decision.

(c)—This subsection defines the breadth of the board's review, which is not substantially different from that of our present BCA provider appeal committee. However, the BCA committee does not review matters which are not germane to the specific items being appealed. This subsection appears to give this board such discretionary power. For the board to make such investigations would require an audit capability to investigate matters not brought before it by a provider or an intermediary. The exercise of this power might defeat some of the judgmental responsibility of the intermediary in originally settling cost reports. Many unauditible or questionable cost items often are settled by the intermediary and the provider through adjustments or estimates in the total context of the cost reports, especially when the amounts are not material. It is our recommendation that the board's purview be limited to those issues in dispute.

UTILIZATION REVIEW—CLAIMS ADMINISTRATION

Utilization review and standards for claims administration also have been matters of continuing concern to Blue Cross and of interest to the Congress and the Administration. Several provisions in H.R. 1 are designed to improve some deficiencies in the programs as they relate to the control of use of service and we support most of those provisions. We recommend, however, that Section 228—which provides for advance approval of extended care and home health coverage under Medicare—be amended to assure that physicians whose reliability in certifying patient need is questioned, be granted the opportunity for notice and hearing. The procedure should be structured to assure that physicians are advised when they make erroneous certifications and then be given an opportunity to present evidence concerning their use of the advance approval procedure.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Professional Standards Review Organization (PSRO), although not included in H.R. 1 as a separate provision, is provided for under Section 222 authorizing the Secretary to develop and engage in experiments and demonstration projects to determine whether areawide or communitywide peer review, utilization review and medical review mechanisms will help assure that health services conform to appropriate professional standards. In our testimony before this committee in September 1970 on H.R. 17550, we commented on Senator Bennett's amendment on professional standards review. We note that the amendment underwent several changes before it was approved by the Committee on Finance. All of the changes were intended to support existing systems of effective utilization review. We were pleased to see changes made at that

time since they recognized existing capability among hospitals and carriers to carry out effective peer review.

The PSRO provision passed by the Senate in 1970, although giving recognition to existing programs, would require ultimately national application of one form of peer review for the Social Security programs. We have reservations about any one form of peer review fitting the country as a whole. The relative role of the PSRO, carriers, and institutional providers must be more realistically appraised and designed to reinforce the strengths of each participant. To limit the primary role to the PSRO whereby beneficiaries of the various titles of the Social Security Act are removed from peer review activities of institutional providers and carriers would seriously diminish the effectiveness achieved through review programs serving both public and private beneficiaries and subscribers.

There clearly is a need for improvements in utilization review techniques and programs. Standards for necessary care are needed and a more workable system of recertification must be found. Gaps do exist in review of home and office services. There is no one best way of meeting those needs, given the variation in health care delivery.

We support the provision in H.R. 1 authorizing the Secretary to experiment with utilization review and peer review systems. Some programs are currently under way and others are beginning to develop. Examples are the Certified Hospital Admission Program in Southern California, the Hospital Utilization Project in Western Pennsylvania and the program in Utah between the Blue Cross and Blue Shield Plan and the Utah State Medical Society. Each of these programs uses the relationship of the medical profession, institutional provider and carriers in a unique way. In Southern California the emphasis is on review at admission to the hospital by registered nurses. Western Pennsylvania uses a technique of data comparison and direct involvement with institutional U.R. committees.

Utah is a blend of medical society, carrier, and institutional pre and post payment review. Though different, each program is uniquely suited to the needs of professional practice in the area and is designed to make best use of the strongest participants in effecting peer review. Those and other programs with other unique organizational characteristics should be encouraged and subjected to evaluation to see what works best.

ESTABLISHMENT OF INSPECTOR GENERAL OFFICE FOR HEALTH ADMINISTRATION

The purpose of the amendment establishing an office of inspector general for health administration is to assure that there is continuous monitoring of the performance of participants in the Medicare and Medicaid programs. Monitoring the performance of these programs is presently a major responsibility of several government agencies through a multiplicity of processes which consume a significant amount of administrative costs. Under Medicare, for Blue Cross alone, there were 630 separate on-site reviews of our contract performance during a recent 12 month period. They included validation reviews, contract performance reviews, level of care reviews, provider based physician reviews, system reviews, on-site representative inspections, HEW audits and GAO reviews. The Inspector General apparently would be an additional review activity to these existing programs.

The role of government under Medicare and Medicaid must include the responsibility to monitor and regulate performance; the challenge is to be specific about objectives and results. Under Medicare and Medicaid, government and private organizations are joined through agreement, each reinforcing the other in seeking the programs' objectives. Under those circumstances the regulated party must be given adequate opportunity to participate in the regulatory process. Means must be found for them to participate in the development of or the seeking of revision in performance objectives to assure understanding of accountability.

The amendment providing for an Inspector General does not appear to serve those purposes. Rather, the role would be further identification of performance defects, a responsibility already assumed by the Administration.

We would recommend that instead of an Inspector General, the Secretary of HEW be authorized to establish within the health component of HEW an internal management mechanism designed to strengthen the internal authority of the Secretary. The system should make program managers responsible for

translating health goals into specific program objectives and evaluating and monitoring the performance of those held accountable for achieving the stated objectives.

HEALTH MAINTENANCE ORGANIZATIONS

The concept of "health maintenance organization" was developed in response to a need, to provide an alternative to the existing health care delivery system. The HMO should be designed to encompass a full range of health care services, dealing with the problem of access for a defined population, and providing an opportunity for incentives and controls on costs and use of services. The two provisions in H.R. 1, Section 226—"Medicare Payments to Health Maintenance Organizations" and Section 240—"Relationships Between Medicaid and Comprehensive Health Care Programs" are designed to present this alternative to beneficiaries of the programs.

The Blue Cross Association supports the HMO concept as a viable alternative form for delivery and financing of health services. A policy statement in support of health maintenance organizations was adopted by the Blue Cross Association Board of Governors on August 12, 1971 (copy attached). The policy statement includes a broad definition of a health maintenance organization and lists nine guidelines for HMO development.

In keeping with our policy and in support of health maintenance organizations as they relate specifically to the provisions in H.R. 1, we suggest that the HMO definition be strengthened in the following basic respects:

1. HMO development should fully utilize consumer involvement in planning and organizing delivery of services; and,
2. certain operational standards—such as use of centralized medical records, sharing of records, major equipment and technical and administrative staffs—should be encouraged in participating medical groups.

We also urge that all HMOs should receive payment for 100 percent of average cost rather than 95 percent with the stipulation that each contracting HMO advise the Secretary annually as to how that payment is applied and how "savings" beyond actual cost shall be used. We recommend that wherever possible, excesses be applied toward the following:

1. expanded benefits beyond Medicare A and B services;
2. reduction of subscriber premium costs; and,
3. the establishment of a contingency reserve, in that order. Arbitrary return of excesses to HEW would weaken incentives to improve efficiency.

We also suggest that there be a provision requiring institutional and physician risk-sharing within Medicare contracting HMOs, and that aspects of the provision concerning reimbursable services be revised to specify clearly that the HMO make formal arrangements for both out-of-area emergency and out-of-area maintenance therapy to Medicare subscribers.

Also, we support the need for controls to guard against selective cancellation of high risk subscribers by HMOs.

Again, we strongly support the HMO concept and are firmly convinced that alternatives to present methods of delivering health care must be found. Blue Cross is working actively to develop alternatives and feels that availability of the HMO option under Medicare could provide a major vehicle by which to make multiple choice a valid option.

Finally, while Section 240 provides that a State Medicaid Plan could contract "with an organization which has agreed to provide care and services in addition to those offered under the state plan to individuals eligible for medical assistance" we doubt whether that language would provide an incentive for Medicaid Plans to contract with or support the development of an HMO. We recommend that this provision permit State Medicaid Plans to contract an HMO which provides the basic Medicaid services.

CHANGES IN MEDICAID

We are aware that the committee is interested in considering significant revisions to the benefits and financing of the Title XIX program beyond the scope of the provisions in H.R. 1 dealing with Medicaid and the Maternal and Child Health Care Programs. In considering the evolution of the Title XIX program, we recognize that its problems are embedded in those of the current health care system, in organization, financing and productivity.

We support the need for a greater federal role in establishing benefits, eligibility and financing in the Medicaid program. The federal role should have as its goals adequate coverage of the poor and near-poor, with effective controls over cost and quality.

We support several provisions in H.R. 1 which are specifically designed to deal with some of the problems in the structure and financing of Medicaid. They include:

Section 207—to establish incentives for states to emphasize comprehensive health care. The financial incentives intended by this provision will support the development of health maintenance organizations and help community-oriented health care services.

Section 237—to establish utilization review requirements for Medicaid providers—is an important addition.

Section 239—to assist in coordinating provider approval programs—will further quality control.

Section 235—to provide financial assistance to the states for development and operation of claims processing and information retrieval systems—is essential. We urge that this provision permit the Secretary to finance management information systems developed by either public or private organizations with demonstrated capability to establish and maintain them.

The following provisions underscore the limitations of state resources and priorities. The significant financial burden of Medicaid on the states will be reduced by the cost-sharing provided in Section 208, by the mandatory payments for families with earnings outlined in Section 209, and by the reduction in covered care and services provided by Section 231.

We also note that states will be relieved of the requirement to move toward comprehensive Medicaid programs under Section 230.

The problems of Medicaid are fundamentally the problems of the health care system. A broader strategy is called for to assure that the poor and near-poor have access to a minimum level of benefits. The high priority for protection should be given to needy families, financed 100 percent through federal funds under federally-established eligibility standards. The strategy also should include provision for more responsible purchase of service, for better management and encouragement of alternative systems of delivering care.

The overall goal should be to amend the Medicaid program as part of a strategy to improve health delivery as well as the financing system. The challenge is to assure that enlargement of the federal role—whether through greater financing or regulation of benefits and eligibility—contributes to improving access to care for those who need it while promoting improvements in the productivity of health services.

Mr. Chairman, we appreciate the opportunity to present our views to your committee today and look forward to continuing to work together with government and others to assure that adequate health care is provided to each and every American.

HEALTH MAINTENANCE ORGANIZATIONS: A POLICY STATEMENT BY BLUE CROSS ASSOCIATION

In the quest for improved access to and greater productivity in the delivery of health services, a great deal of interest has centered on Health Maintenance Organizations (HMOs) in recent months. While lacking in precise definition, the HMO is generally characterized as an organized health care delivery system which promotes early detection and continuity of care by an arrangement which holds a single organization responsible for assuring delivery of an agreed set of institutional and physician services to an enrolled population for a stipulated period of time in exchange for a fixed and periodic payment.

There is great latitude in terms of what types of organizations or quasi-organizations may qualify as HMOs; the HMO is not limited to a particular organizational delivery form, provider reimbursement mechanism, enrollee payment or financing source. Rather, it is a concept designating performance criteria to which a variety of systems may adhere insofar as each integrates (1) an overarching point of fiscal, legal and administrative accountability with (2) a planned and coordinated service delivery system comprised of institutional and individual providers, (3) a review, evaluation and control mechanism, (4) an enrollment mechanism, and (5) a consumer payment mechanism.

Recognizing that the basic concepts are not yet well developed and will long be subject to varying interpretation, Blue Cross supports the HMO concept as a promising alternative form for delivery of health services in much the same vein as it has previously supported and been actively involved with development of prepaid group practice programs. In line with this commitment, Blue Cross has helped to establish new prepaid group practice plans and has provided these new systems with critical access to large markets by offering the public the program benefits on a dual or multiple choice basis in open competition with more traditional insurance and delivery systems.

In a similar manner, Blue Cross will promote the growth of HMOs by stimulating their expansion through the marketing mechanism and by establishing new programs in which Plans themselves will operate HMOs. To support these developments, Blue Cross will support the removal of artificial restrictions such as anti-group practice, anti-corporate practice of medicine, and certain other licensure laws.

HMOs will be expensive to launch. Substantial federal grants and loans will be needed. In many areas, an approach geared to building and elaborating on existing resources will be required in order to permit greater development with the limited capital and start-up funds which will be available.

When assisting HMO development, Blue Cross will be guided by the following policies:

(1) An HMO should be required to provide and make accessible to its enrollees full comprehensive care (beyond the connotation of pending legislation) with strong emphasis on primary care and health education. It should use its potential to influence social and cultural forces which impact on health.

(2) HMO development should fully utilize consumer involvement in the planning and organization of delivery of services.

(3) HMOs should be within the purview of planning agencies to prevent the creation of duplicate capacity and to ensure that community, program and facility needs are best served. A variety of organizational forms and methods of governance should develop. But to introduce these new schemes to the existing autonomous and heterogeneous health care systems clearly requires realistic coordination and regulation of health care delivery on a community or regional basis.

(4) Evaluation should be an inherent part of every HMO. At this stage of preliminary development, divergent systems are presented with the unique opportunity to establish a fact and data base that will permit careful and realistic assessment of the effect of such factors as changed manpower usage, alternative payment, reimbursement and delivery methods. This opportunity should not be lost in a short-sighted effort at hasty implementation.

The efficacy of the HMO option has yet to be systematically analyzed and correlated with performance criteria; however, comparison and results can only be derived from systematic analysis of functioning systems. Evaluation and development must occur simultaneously over time.

(5) The HMO should be required to utilize a mechanism for evaluation of institutional utilization and to provide a mechanism for internal peer review.

(6) Any provider reimbursement methods adopted by the HMO should promote some provider risk sharing. Physicians and providers (through methods such as prepaid group practice, capitation payments, and prospective reimbursement) should in some way share responsibility for HMO efforts to provide for greater efficiency of patient care for both Medicare and non-Medicare enrollees.

(7) The HMO can help to meet the acute need which exists in many underfinanced and medically needy poor and rural areas. Emphasis should be placed on providing an effective mechanism for improving access to its services for residents in such areas and for other under-served population segments.

(8) The HMO should provide for open enrollment periods at least annually.

(9) The HMO should provide a mechanism for out-of-area coverage, emergency services and referral services and should attempt to minimize as much as possible the need for cash indemnity in these areas.

During the next decade which will be needed for HMO development and expansion, HMOs competing with more traditional delivery systems for consumer acceptance can provide a stimulus for progress. The outcome of these developments will depend upon the extent to which the HMO and the more traditional financing and delivery systems recognize that each is a viable option among other competing alternative delivery systems.

Progress will be reflected in the degree to which the HMO and traditional modes of care are able to produce payoff in terms of cost and health status through competitive systems which make dual or multiple choice valid and meaningful options. There is no magic inherent in HMOs. Solutions to cost and access problems are to be found in better organization and management, and real options. Even with appreciable success, the majority of care in the foreseeable future is likely to be rendered in traditional settings. The efficacy of the HMO will hinge upon its ability to promote a variety of alternatives without confining change to financing alone and without allowing flexibility of organization to foster the illusion of change while the delivery system continues to serve itself in traditional ways.

The CHAIRMAN. Thank you very much, sir.

This concludes the public portion of H.R. 1, the President's welfare expansion bill.

On Tuesday, February 15, the committee will have a 1-day hearing inquiring into the effectiveness of the 168 antipoverty programs described on page 195 of the committee hearings on H.R. 1, dated July 27, 1971.

Testifying at this hearing will be the Honorable George P. Shultz, Director of the Office of Management and Budget; the Honorable Elliot L. Richardson, Secretary of the Department of Health, Education, and Welfare; the Honorable James Hodgson, Secretary of the Department of Labor; and Philip V. Sanchez, Director of the Office of Economic Opportunity.

Thank you.

(Whereupon, at 3:50 p.m., the public hearings in this subject matter were concluded, the committee to reconvene on Tuesday, February 15, 1972, for a 1-day hearing on the 168 antipoverty programs described above.)



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